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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: ENWF

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: **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 **06/06/2016** (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):

Mandatory DPNA, effective 05/01/16, is discontinued effective 05/18/16.

17. SURVEYOR SIGNATURE — Date :
Jennifer Bahr, HFE NE II — 06/06/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 06/17/2016 (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 07/12/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/10/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245438
June 17, 2016

Ms. Marlene Smith, Administrator
Talahi Nursing & Rehab Center
1717 University Drive Southeast
Saint Cloud, Minnesota 56304

Dear Ms. Smith:

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 May 18, 2016, 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
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 17, 2016

Ms. Marlene Smith, Administrator
Talahi Nursing & Rehabilitation Center
1717 University Drive Southeast
Saint Cloud, Minnesota 56304

RE: Project Number S5438027 & H5438044

Dear Ms. Smith:

On February 17, 2016, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective February 22, 2016. (42 CFR 488.422)

On February 23, 2016, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Per day civil money penalty of $4800.00, effective January 28, 2016 and continuing through January 31, 2016 for a total of $19,200.00 (42 CFR 488.430 through 488.444)

- Per day civil money penalty of $250.00 effective May 1, 2016 (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 1, 2016. (42 CFR 488.417 (b))

Also, the CMS Region V Office notified you in their letter of February 23, 2016, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 1, 2016.

This was based on the deficiencies cited by this Department for an extended survey completed on February 1, 2016 that included an investigation of complaint number H5438044, and a Federal Monitoring Survey (FMS) completed on February 9, 2016. The most serious deficiencies were found to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required.

On April 29, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on February 1, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 18, 2016. Based on our visit, we determined that your facility had not corrected the deficiencies issued pursuant to our extended survey, completed on February 1, 2016. As a result of the revisit findings, we notified you that the Category 1 remedy of state monitoring would remain in effect.

In addition, compliance with the Life Safety Code (LSC) deficiencies issued pursuant to the February 1, 2016 extended survey and the February 9, 2016, Federal Monitoring Survey (FMS) had not been verified. The most serious LSC deficiencies in your facility at the time of the extended and FMS surveys were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On June 6, 2016, the Minnesota Department of Health completed a PCR and on May 16, 2016 the Minnesota Department of Public Safety completed both an FMS and an LSC PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on April 29, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 18, 2016. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on April 29, 2016. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective May 18, 2016.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of :

- Federal Civil Money Penalty of $4,800.00 per day for the four (4) days beginning January 28, 2016 and continuing through January 31, 2016 for a total of $19,200.00 to remain in effect. (42 CFR 488.430 through 488.444)

- Federal Civil Money Penalty of $250.00 per day beginning February 1, 2016 be discontinued effective May 18, 2016 (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 1, 2016 be discontinued effective May 18, 2016. (42 CFR 488.417 (b))

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition.

As we notified you in our letter of February 17, 2016, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 1, 2016.

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, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245438 Y1	A. Building B. Wing Y2	6/6/2016 Y3

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0225	Correction	ID Prefix F0226	Correction	ID Prefix F0323	Correction
Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4)	Completed	Reg. # 483.13(c)	Completed	Reg. # 483.25(h)	Completed
LSC	05/18/2016	LSC	05/18/2016	LSC	05/18/2016
ID Prefix F0520	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.75(o)(1)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	05/18/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) PK/KJ	DATE 06/17/2016	SIGNATURE OF SURVEYOR 35575	DATE 06/06/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON
2/1/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245438 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	5/16/2016 Y3

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0025	03/25/2016	LSC K0046	03/25/2016	LSC K0048	03/25/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0050	03/25/2016	LSC K0052	03/25/2016	LSC K0054	03/25/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0062	03/25/2016	LSC K0144	03/25/2016	LSC K0154	03/25/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0155	03/25/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	PK/KJ	06/17/2016	35575	05/16/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
2/9/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: ENWF

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: **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 **04/29/2016** (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:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	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):
Mandatory DPNA is effective May 1, 2016.

17. SURVEYOR SIGNATURE — Date :
LoAnn DeGagne, HFE NE II 05/25/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 06/24/2016 (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) **00**

VOLUNTARY
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 07/12/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/10/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 13, 2016

Ms. Marlene Smith, Administrator
Talahi Nursing & Rehabilitation Center
1717 University Drive Southeast
Saint Cloud, Minnesota 56304

RE: Project Number S5438027, H5438043 & H5438044

Dear Ms. Smith:

On February 17, 2016, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective February 22. (42 CFR 488.422)

On February 23, 2016, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Federal Civil Money Penalty of $4,800.00 per day for the four (4) days beginning January 28, 2016 and continuing through January 31, 2016 for a total of $19,200.00 (42 CFR 488.430 through 488.444)

- Federal Civil Money Penalty of $250.00 per day beginning February 1, 2016 (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 1, 2016. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for an extended survey completed on January 28, 2016 that included an investigation of complaint number H5438044. The most serious deficiencies were found to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required.

On April 29, 2016, the Minnesota Department of Health completed a Post Certification Revisit to verify

that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on January 28, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 18, 2016. Based on our visit, we have determined that your facility has not obtained substantial compliance with the deficiencies issued pursuant to our extended survey, completed on January 28, 2016. The deficiency(ies) not corrected is/are as follows:

F0225 -- S/S: D -- 483.13(c)(1)(ii)-(iii), (c)(2) - (4) -- Investigate/report Allegations/individuals
F0226 -- S/S: D -- 483.13(c) -- Develop/implment Abuse/neglect, Etc Policies
F0323 -- S/S: J -- 483.25(h) -- Free Of Accident Hazards/supervision/devices
F0520 -- S/S: F -- 483.75(o)(1) -- Qaa Committee-Members/meet Quarterly/plans

The most serious deficiencies in your facility were found to be isolated deficiencies that constituted immediate jeopardy (Level J), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of the revisit findings, the Category 1 remedy of state monitoring will remain in effect.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of February 23, 2016:

- Per day civil money penalty will remain in effect. (42 CFR 488.430 through 488.444)

- Per instance civil money penalty will remain in effect. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 1, 2016 remain in effect. (42 CFR 488.417 (b))

Based on the findings of this visit, we are recommending to the CMS Region V Office the following additional remedy:

- Federal Civil Money Penalty for the four (4) days beginning January 28, 2016 and continuing through January 31, 2016 be increased by the two (2) days beginning April 28, 2016 and continuing through April 29, 2016. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

As we notified you in our letter of February 17, 2016, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 1, 2016.

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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

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
St. Cloud B Survey Team
Licensing & Certification
Health Regulation Division
Midtown Square
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7343
Fax: (320)223-7348

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,

- Include electronic acknowledgement signature of provider and date.

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. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

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 May 1, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
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 _____	R 04/29/2016

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 An onsite resurvey was conducted by surveyors of this department on 4/25, 4/26, 4/27, 4/28 and 4/29/16, to determine compliance with Federal deficiencies issued during a recertification survey exited on 2/1/16. The certification tags that were corrected can be found on the CMS 2567B. Tag/s that were not corrected at the time of the onsite revisit are documented on a CMS 2567. The resurvey resulted in an Immediate Jeopardy (IJ) at F323 related to the facility's failure to implement appropriate response for a resident who experienced behavioral changes and sustained falls with injury. The IJ was identified on 4/28/16, at 1:31 p.m., when the team had deterined the resident's was at immediate risk due to multiple falls resulting in injury and the facility's failure to ensure assessment had been conducted, and intervention developed, to prevent further falls and to reduce the risk of significant injury. The IJ was removed on 4/29/16, at 5:24 p.m., when the facility had implemented interventions including assessment, initiation of a new wheelchair, and education of staff. At the time of the resurvey, a revisit was also conducted for deficiencies issued in relation to complaint #H5438043 which had been investigated during the standard survey exited an 2/1/16. The deficiencies that had been issued related to #H5438043 were corrected. The facility's plan of (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	{F 000}		

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

Electronically Signed

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.

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 _____	R 04/29/2016

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}	Continued From page 1 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 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 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.	{F 225}		5/18/16

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 _____	R 04/29/2016

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 225}	Continued From page 2 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 ensure allegations of neglect were immediately reported to the state agency (SA) and/or thoroughly investigated for 2 of 7 residents (R39 and R68) reviewed for abuse and neglect. Findings include: R68's annual MDS dated 4/1/16, indicated she was cognitively intact, had scheduled and PRN (as needed) pain medications and experienced almost constant pain. R68's care plan dated 3/28/16, indicated she had pain in unspecified limb. An Incident Report dated 3/22/16, indicated "Writer spoke with [R68] at approximately 1400 on 03/21/2016 regarding concerns of medication running out too soon. [R68] described medications that she takes on a daily basis and adamantly denied taking any medications between the hours of 0600-0700, especially pain medication. [R68] also stated that [employee-A] was making a lot of 'mix-ups,' and 'looked not from this planet'." The Incident Report further	{F 225}	F225 The occurrences of R68 and R39 were reviewed and reported to OHFC and investigations were complete. It is the policy of Talahi to ensure all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the officials in accordance with State law. It is the policy of Talahi to thoroughly investigate all violations of alleged mistreatment, neglect, or abuse and to prevent further abuse while the investigation is in progress. Talahi□s policies and procedures regarding the VA process have been reviewed and have been found to be complete. Staff have been re-educated to the reporting process and investigation process, and to the VA binder, located at each nursing station, which contains the VA process, definitions, and contact information. Staff have been re-educated on the investigation procedure and reporting	

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 _____	R 04/29/2016

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 225}	Continued From page 3 indicated that human resources (HR) met with employee (E)-A on 3/22/16, and "Brought up concerns from Saturday, and discussed past narcotic discrepancies, and guidelines that need to be followed." E-A was told her position was terminated, and she stated, "Okay, you have to do what you have to do." [E]-A signed the termination form and had no other information to give, and she was escorted from the building. The Incident Report further indicated an Investigative Report had been submitted to the State Agency on 3/22/16, the day after the facility had become aware of the incident. During interview with the nurse consultant (NC) on 4/28/16, at 9:41 a.m., the NC stated the director of nursing (DON) reports incidents to the State Agency and that she and the DON had looked at this issue as a potential diversion of medications, and had focused on that. The NC stated the administrator was notified immediately, and verified the incident should also have been reported to the State Agency immediately. R39's significant change Minimum Data Set (MDS) dated 2/18/16, indicated the resident had diagnoses including dementia and anxiety, had severe cognitive impairment, had no behaviors, required extensive staff assistance with all activities of daily living (ADL's), had 2 or more falls since the prior MDS assessment (12/21/15), took antianxiety medication daily, and had no restraints. R39's care plan dated 4/25/16, indicated the resident was at risk for falls due to use of psychotherapeutic medication, decreased strength and ambulation, not always aware of surroundings, and self limitations and physical	{F 225}	obligations. The Narcotic Discrepancy Investigation tool has been reviewed and has been found to be complete. It was impossible to conclude the disposition of the medication in question of R68. After a thorough investigation the findings were inconclusive. DON or designee will complete daily audits of Progress Notes and Risk Management/ Incident Report Log to insure proper reporting has been done and investigation process is initiated and completed, this will be continued until the QAPI meeting on June 12, at which time on going frequency will be determined by that committee. The IDT meets every week day and reviews the prior days, or weekend, VA reports and audits for timely notification and complete investigation, this is an ongoing system and it is included in the Daily Administrators Report. All audits are reviewed at the monthly QA meetings. DON/Designee, Administrator Responsible.	

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 _____	R 04/29/2016

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 225}	Continued From page 4 mobility. Staff were directed to use a high/ low bed and keep it in the lowest position while in bed, in line sight of nursing staff when utilizing the tilt and space wheelchair (a wheelchair that reclines back), offer ambulation with attempts to stand from chair, tab alarm on at all times, take for walks outside, close one to one (which was added to the care plan on 4/25/16), and to use reclined position in tilt and space wheelchair when not at meals. R39's Nursing assistant (NA) care sheet (a reference NA's use regarding specific care for residents) dated 4/24/16, directed staff R39 was at high risk for falls and to ensure the bed was in the lowest position, use tab alarm at all times, "recline position in tilt and space wheelchair, in line sight of nursing staff when wheelchair utilized," and to offer snack, juice, show birds, or go outside when the resident is anxious. During observation on 4/25/16, at approximately 2:30 p.m. R39 was observed in a tilt-in-space wheelchair reclined approximately 10 degrees, and R39 had a large lump on her forehead above her right eye, and her forehead was discolored yellow, green, and light and dark blue. R39's occupational therapy notes dated 2/11/16, indicated "Nursing staff educated to have visual of the pt (patient) while seated in tilt-in-space w/c (wheelchair) secondary to risk of falls and pt hx (history) of getting up independently when left alone..." The OT- Therapist Progress and Discharge Summary dated 3/4/16, indicated under discharge plans and instructions, "D/C to nursing staff with recommendations for positioning, observation while seated in w/c, and assistance with self feeding." Review of a QA Post Fall investigation dated	{F 225}		

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 _____	R 04/29/2016

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 225}	Continued From page 5 4/20/16, at 9:20 p.m. indicated, "Resident noted to have eyes closed while in wheelchair in common area, when writer turned corner, writer heard tabs alarm sound and a thud. Resident noted to be on ground, on left side in fetal position." The interventions listed that were in place prior to the fall were 15 minute checks, and tab alarm. The interventions that were put into place related to this fall were, "To be with staff when up in wheelchair." Although the intervention of having resident in staff sight while up in wheelchair had been implemented on 2/11/16, this was not done on 4/20/16. During interview on 4/27/16, at 10:05 a.m. occupational therapist (OT)-A stated she had worked with R39 from 2/10/16, to 3/4/16, and upon discharge had instructed staff to ensure R39 was within staff sight at all times when in wheelchair to prevent falls. During interview on 4/27/16, at 12:37 p.m. consultant nurse (CN) stated R39's case manager did the investigations for the recent change in behaviors and falls, however, she was not currently working, and she would need to contact her to see where the information was located. CN stated when R39 fell the evening of 4/20/16, staff were not following the residents plan of care, and staff were disciplined and re-educated. However, CN stated the neglect of care had not been reported to the state agency. During phone interview on 4/28/16, at 12:45 p.m. RN-B (who was R39's case manager) stated she had completed all of R39 fall assessments and implemented interventions. RN-B stated R39's fall the evening of 4/20/16, was not reported to the State Agency as it was being dealt with	{F 225}		

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 _____	R 04/29/2016

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 225}	Continued From page 6 internally. RN-B stated she'd told the DON about the fall, and wasn't sure what happened after that. RN-B stated she was in the process of disciplining 3 staff regarding the fall the evening of 4/20/16, due to staff not following the care plan intervention to have R39 in their sight while in the wheelchair however, RN-B stated the discipline had not been completed yet as she had not seen the specific staff since 4/20/16. Although the facility was aware staff were not following the plan of care for R39 on 4/20/16, which resulted in a fall, this was not reported to the state agency.	{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 their abuse prohibition policy which required all allegations of neglect be immediately reported to the state agency (SA) and/or thoroughly investigated for 2 of 7 residents reviewed (R39 and R68). Findings include: The facilities Resident Protection Policy And Procedure revised 3/18/16, indicated "A mandated reporter shall make a report to the	{F 226}	F226 The occurrences of R68 and R39 were reviewed and reported to OHF and investigations were complete. It is the policy of Talahi to ensure all alleged violations involving Abuse and and/or Neglect are reported immediately to the officials in accordance with State law. It is the policy of Talahi to thoroughly investigate all violations of alleged neglect, or abuse and to prevent further abuse while the investigation is in	5/18/16

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 _____	R 04/29/2016

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 226}	Continued From page 7 state reporting agency immediately of alleged incident. The report must be of sufficient content..." The policy further indicated under neglect, "The failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. The failure or omission by a caregiver to supply a vulnerable adult with care or services including, but not limited to, food clothing, shelter, health care, or supervision." R68's annual MDS dated 4/1/16, indicated she was cognitively intact, had scheduled and PRN (as needed) pain medications and almost constant pain. R68's care plan dated 3/28/16, indicated she had pain in unspecified limb. An Incident Report dated 3/22/16, indicated "Writer spoke with [R68] at approximately 1400 on 03/21/2016 regarding concerns of medication running out too soon. [R68] described medications that she takes on a daily basis and adamantly denied taking any medications between the hours of 0600-0700, especially pain medication. [R68] also stated that [employee-A] was making a lot of 'mix-ups,' and 'looked not from this planet." The Incident Report further indicated that human resources (HR) met with employee (E)-A on 3/22/16, and "Brought up concerns from Saturday, and discussed past narcotic discrepancies, and guidelines that need to be followed." E-A was told her position was terminated, and she stated, "Okay, you have to do what you have to do." [E]-A signed the termination form and had no other information to give, and she was escorted from the building. The Incident Report further indicated the Investigative Report was submitted to the state agency on 3/22/16, the day after the facility was	{F 226}	progress. Talahi□s policies and procedures regarding the Abuse and Neglect process have been reviewed and have been found to be complete. Staff have been re-educated to the reporting process and investigation process, and to the Abuse and Neglect. Staff have been re-educated on the investigation procedure and reporting obligations. DON or designee will complete daily audits of Abuse and Neglect Progress Notes and Risk Management/ Incident Report Log to insure proper reporting has been done and investigation process is initiated and completed, this will be continued until the QAPI meeting on June 12, at which time on going frequency will be determined by that committee. The IDT meets every week day and reviews the prior days, or weekend, Abuse and Neglect reports and audits for timely notification and complete investigation, this is an ongoing system and it is included in the Daily Administrators Report. All audits are reviewed at the monthly QA meetings.	

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 _____	R 04/29/2016

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 226}	Continued From page 8 aware of the incident. During interview 4/28/16, at 9:41 a.m. nurse consultant (NC) stated the director of nursing (DON) reports the incidents to the state agency and that her and the DON looked at this as a potential diversion of medications and were focused on that. The NC stated the administrator was notified immediately and the incident should have been reported to the state agency immediately according to the facility policy. Although the facility was aware of the incident on 3/21/16, it was not reported to the state agency immediately according to the facility policy. R39's significant change Minimum Data Set (MDS) dated 2/18/16, indicated the resident had diagnoses including dementia and anxiety, had severe cognitive impairment, had no behaviors, and required extensive staff assistance with all activities of daily living (ADL's). R39's care plan dated 4/25/16, indicated the resident was at risk for falls due to use of psychotherapeutic medication, decreased strength and ambulation, not always aware of surroundings, and self limitations and physical mobility. Staff were directed to use a high/ low bed and keep it in the lowest position while in bed, in line sight of nursing staff when utilizing the tilt and space wheelchair (a wheelchair that reclines back), offer ambulation with attempts to stand from chair, tab alarm on at all times, take for walks outside, close one to one (which was added to the care plan on 4/25/16), and to use reclined position in tilt and space wheelchair when not at meals. R39's Nursing assistant (NA) care sheet (a reference NA's use regarding specific care for	{F 226}		

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 _____	R 04/29/2016

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 226}	Continued From page 9	{F 226}		

residents) dated 4/24/16, directed staff R39 was at high risk for falls and to ensure the bed was in the lowest position, use tab alarm at all times, "recline position in tilt and space wheelchair, in line sight of nursing staff when wheelchair utilized," and to offer snack, juice, show birds, or go outside when the resident is anxious.
During observation on 4/25/16, at approximately 2:30 p.m. R39 was observed in a tilt-in-space wheelchair reclined approximately 10 degrees, and R39 had a large lump on her forehead above her right eye, and her forehead was discolored yellow, green, and light and dark blue.
R39's occupational therapy notes dated 2/11/16, indicated "Nursing staff educated to have visual of the pt while seated in tilt-in-space w/c secondary to risk of falls and pt hx [history] of getting up independently when left alone..."
The OT- Therapist Progress and Discharge Summary dated 3/4/16, indicated under discharge plans and instructions, "D/C to nursing staff with recommendations for positioning, observation while seated in w/c, and assistance with self feeding."
Review of a QA Post Fall investigation dated 4/20/16, at 9:20 p.m. indicated, "Resident noted to have eyes closed while in wheelchair in common area, when writer turned corner, writer heard tabs alarm sound and a thud. Resident noted to be on ground, on left side in fetal position." The interventions listed that were in place prior to the fall were 15 minute checks, and tab alarm. The interventions that were put into place related to this fall were, "To be with staff when up in wheelchair." Although the intervention of having resident in staff sight while up in wheelchair had been implemented on 2/11/16, this was not done on 4/20/16.

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 _____	R 04/29/2016

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 226}	Continued From page 10	{F 226}		

During interview on 4/27/16, at 10:05 a.m. occupational therapist (OT)-A stated she had worked with R39 from 2/10/16, to 3/4/16, and upon discharge had instructed staff to ensure R39 was within staff sight at all times when in wheelchair to prevent falls.

During interview on 4/27/16, at 12:37 p.m. consultant nurse (CN) stated R39's case manager did the investigations for the recent change in behaviors and falls, however, she was not currently working, and she would need to contact her to see where the information was located. CN stated when R39 fell the evening of 4/20/16, staff were not following the residents plan of care, and staff were disciplined and re-educated. However, CN stated the neglect of care had not been reported to the state agency according to the facility policy.

During phone interview on 4/28/16, at 12:45 p.m. RN-B (who was R39's case manager) stated she had completed all of R39 fall assessments and implemented interventions. RN-B stated R39's fall the evening of 4/20/16, was not reported to the state agency as it was being dealt with internally. RN-B stated she told the DON about the fall, and wasn't sure what happened after that. RN-B stated she was in the process of disciplining 3 staff regarding the fall the evening of 4/20/16, due to staff not following the care plan and having R39 in their sight while in the wheelchair, however, the discipline had not been completed yet as she had not seen the specific staff since 4/20/16.

Although the facility was aware staff were not following the plan of care for R39 on 4/20/16, which resulted in a fall, this was not reported to

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 _____	R 04/29/2016

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 226}	Continued From page 11 the state agency according to facility policy.	{F 226}		
{F 323} SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident falls were comprehensively assessed and interventions were implemented to prevent falls for 1 of 3 residents (R39) reviewed with falls. The facility failed to investigate and comprehensively assess the resident's falls to determine whether new interventions should have been implemented, and the facility failed to ensure interventions currently in place were adequate and consistently implemented to minimize the risk for further falls. The facility's failure resulted in an immediate jeopardy for R39. Findings include: The immediate jeopardy began on 4/20/16, when it was identified R39's safety was at immediate risk due to a change in behavior resulting in falls with injury. Although the facility was aware of R39's recent falls and changes in behavior, the facility failed to comprehensively assess, develop further interventions, and/ or ensure current interventions were consistently being implemented by staff. On 4/28/16, at 1:28 p.m.	{F 323}	F323 The removal plan identified on 4/29/16 was implemented on that date for R39 including: Initially implemented 1:1 staffing to be with R39 for 24 hours while up in the wheelchair, and then reassessed by nursing for ongoing need. OT fitted R39 for a different wheelchair with a full, attached lap tray and assessed the resident was safe. Root cause analysis was done for all prior falls, 30 minute checks were implemented while in bed, a sleep study was started, Medication review was completed by pharmacist and physician, and assessments were completed including pain, fall risk, safety, restraint, head to toe, and bowel and bladder. R39□s care plan was updated to include specific instructions on the current wheelchair and lap tray use, R39 was provided a sensory activity basket to decrease agitation, staff were directed if R39 becomes agitated to attempt specific	5/18/16

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 _____	R 04/29/2016

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 323}	Continued From page 12 the facility administrator, director of nursing (DON), and facility nurse consultant (NC) were notified of the immediate jeopardy (IJ) for R39. The IJ was removed on 4/29/16, at 5:24 p.m. but noncompliance remained at an isolated scope and severity level, with actual harm sustained that is not immediate jeopardy (Level G). R39 was observe at 2:30 p.m. on 4/25/16, seated in a tilt-in-space wheelchair which was reclined approximately 10 degrees. R39 was observed to have a large lump on her forehead above her right eye, and her forehead was discolored yellow, green, light and dark blue, and light purple. R39 was in the dayroom in the Rosewood unit (locked unit) with a NA (nursing assistant) sitting directly next to her. During interview on 4/25/16, at 3:10 p.m. NA-A stated staff had been directed earlier that day to stay with R39 while up in her wheelchair because she had fallen "several times" over the past week out of the tilt-in-space wheelchair. R39's significant change Minimum Data Set (MDS) dated 2/18/16, indicated the resident had diagnoses including dementia and anxiety, had severe cognitive impairment, had no behaviors, required extensive staff assistance with all activities of daily living (ADL's), had two or more falls since the prior MDS assessment (12/21/15), was prescribed antianxiety medication daily, and had no restraints. R39's care area assessment (CAA) dated 3/1/16, indicated the resident, "Suffers from immobility issues and uses tilt-space chair for sitting/ support," had impaired verbal communication secondary to diagnoses of: decline in cognition, dementia, mood disorder, Alzheimer's disease, delirium, and depressive disorder, and was unable to make her self understood, and did not always understand others.	{F 323}	non-pharmacological approaches. All staff were educated on new care plan interventions for R39, as well as how to utilize the wheelchair and lap tray. An audit, of all residents, was conducted to identify potential triggers for elevated risk of falls: Change in condition or significant change in last month, including review of infection control, Incident Reports, and a look back at any CAA that may have triggered as a fall risk. Root Cause review of falls in the past month have also been conducted including review of interventions and effectiveness. Initiated a review of all residents with a change in medications in the last 4 weeks for medication type and Compliance with monitoring for changes with medication changes. We initiated an immediate Audit of fall care plans and group care sheets to ensure interventions are current and accurate. The Falls Committee has been re-established and will meet weekly with members of the IDT. The Falls Committee will set goals to decrease falls and monitor new falls. It will strengthen and support the falling leaf monitoring system. A Falls Intervention Tracking Sheet has been re-established and staff have been re-educated to the use of this tool. A tool containing Strategies to Reduce Falls has been re-introduced and staff have been re-educated. Fall interventions identified post assessment will be added to the resident care plan.	

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 _____	R 04/29/2016

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 323}	Continued From page 13 R39's care plan dated 4/25/16, indicated the resident was at risk for falls due to use of psychotherapeutic medication, decreased strength and ambulation, not always aware of surroundings, and self-limitations and physical mobility. Staff were directed to use a high/low bed and keep it in the lowest position while in bed, in line sight of nursing staff when utilizing the tilt and space wheelchair (a wheelchair that reclined), offer ambulation with attempts to stand from chair, TABS alarm on at all times, take for walks outside, close one to one (which was added to the care plan on 4/25/16), and to use reclined position in tilt and space wheelchair when not at meals. Although the care plan directed staff to recline the tilt and space wheelchair when the resident was not at meals, there were no specific instructions on how far to recline R39. R39's NA care sheet (a reference NA's used regarding specific care for residents) dated 4/24/16, directed staff R39 was at high risk for falls and to ensure the bed was in the lowest position, use TABS alarm at all times, "recline position in tilt and space wheelchair, in line sight of nursing staff when wheelchair utilized," and to offer snack, juice, show birds, or go outside when the resident is anxious. Although the NA care sheet directed staff to recline the tilt and space wheelchair, there were no specific instructions on how far to recline R39 when utilizing the wheelchair. R39's Morse Fall Scale dated 2/12/16, indicated the resident had impaired gait, and overestimated or forgot limits of mobility. The resident's fall risk score was 75, which indicated high risk for falls. Occupation therapy notes for R39 dated 2/10/16 to 3/4/16, included the following: 2/10/16- "Patient was seen on this date to assess	{F 323}	The Fall Scene Investigation Report has been re-established and staff have been re-educated to its proper use. An IDT Post Fall Investigation/Summary has been re-introduced and staff have been re-educated to its use. A Fall Report Checklist has been developed to guide staff through the proper steps to take after a fall. Including notification of appropriate persons and education and communication to staff. Staff have been re-educated to the Fall Scene Investigation Report. A representative from Therapy is present at weekday stand up IDT meetings. The representative present will communicate with their department needs identified at this meeting. DON/designee is Responsible	

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 _____	R 04/29/2016

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 323}	Continued From page 14 positioning while seated in current Broda Chair [wheelchair which could be reclined] which is to return with the hospice company upon the patients d/c [discharge] from hospice services on 2/10/[16]. Plan to implement alternative seating system to allow patient to maintain upright posture for the majority of the day as she does currently. Consulted with hospice nursing staff and facility nursing staff regarding patient's positioning. Unsure of reasoning for patient positioned with a lap tray while in her Broda chair, hospice notes it may have been secondary to patient's behaviors during attempts to complete basic self cares. Patient is also noted to have her hips sliding forward in the chair, the lap tray may be assisting with appropriate positioning . Nursing staff report patient demonstrates poor trunk control when outside of her current seating system...." In addition, 2/10/16 follow up documentation included: "Patient was trialed in tilt-in-space w/c [wheelchair] as an alternative to the Broda chair that hospice care had her positioned in. Patient's family has requested the lap tray continue to be used however, family was educated on alternative ways to maintain pt's [patient's] independence with the use of lap tray...Plan to educate nursing staff to utilize tilt option to minimize any fall risk for pt... Nursing staff educated on positioning to minimize risk for falls and to increase pt's participation in basic self cares. Educated nursing staff that pt should be in their line of sight at all times secondary to new seating system and to reduce the risk of falls." 2/11/16- "Nursing staff educated to have visual of the pt while seated in tilt-in-space w/c secondary to risk of falls and pt hx [history] of getting up independently when left alone. Pt's family would like pt to continue the use of lap tray both to	{F 323}		

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 _____	R 04/29/2016

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 323}	Continued From page 15 increase independence with self-feeding activities and to decrease the risk of falls from her w/c. Consult with nursing and plan to attempt to provide safe and effective positioning without the use of a lap tray and /or other restraints...Per nursing pt had a fall today and requested the use of a 'seat belt' built into the current tilt-in-space w/c. OT believes pt would benefit more from the placement of a lap tray rather than restraint with a seat belt to reduce the risk of falling... Communication submitted to recommend pt be positioned in a recline position and be visible to nursing staff at all times when she is up in her w/c... Attempted to trial lap tray on this date with pt but she became upset and refused to allow OT to position the lap tray on this date. Plan to consult with nurse manager." A fax to R39's physician from nursing dated 2/15/16, indicated, "Resident currently has order for laptray for safety and positioning ... is using tilt-in-space, which lap tray does not work with. Can we get orders to d/c (discharge) laptray?" 2/18/16- "Consulted with nurse manager on this date regarding lap tray and/ or seat belt use with pt. Nurse manager feels that this will not benefit the resident and believes the TABS alarm and recommendations for pt to be in the line sight of nursing staff reduces the pt's risk of falls. OT agrees that lap tray will not increase pt's participation in basic self cares." Although the facility had faxed the physician on 2/15/16, indicating the lap tray would not work with the current wheelchair; and OT had indicated a lap tray could benefit R39 and decrease the risk of falling in their 2/11/16 note, there was no indication an alternate wheelchair, that a lap tray could be used with, had been assessed or trialed. 3/4/16- "Pt to be d/c on this date as she has met long term goals previously established. Nursing	{F 323}		

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 _____	R 04/29/2016

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 323}	Continued From page 16	{F 323}		

staff educated on postioning recommendations and level of assistance to provide for self-feeding. Pt noted to demonstrate safe and effective w/c positioning while seated in tilt-in-space w/c for meal time."
The OT- Therapist Progress and Discharge Summary dated 3/4/16, indicated under discharge plans and instructions, "D/C to nursing staff with recommendations for positioning, observation while seated in w/c, and assistance with self feeding." Although the OT notes indicated nursing was educated on positioning recommendations, there were no specific recommendations identified which directed staff how far R39 was to be reclined back in the tilt-in-space wheelchair to prevent falls.
The most recent Safety Risk Data Collection for R39 dated 12/19/15, indicated R39's risk factors for falls included: balance problems, pain, incontinence, impaired vision, decline in decision making skills, impulsiveness, dementia, behaviors, restraint use, and physical devices. The Safety Risk Data Collection indicated the resident used half side rails, bed TABS alarm, and a lap tray, related to medical symptoms/ diagnoses of balance problems, impulsive/ physical behaviors, and requiring assistance. Although R39 no longer had a lap tray in place and had been using a tilt-in-space wheelchair with no lap tray, no further Safety Risk Data Collection had been completed to assess R39's current safety devices.
Review of R39's falls since implementation of the tilt-in-space wheelchair 2/10/16, indicated the following:
2/11/16- The Progress Note dated 2/11/16, at 12:28 p.m. indicated the resident was, "Out in the main dining room with activities. Res [resident] left unattended and res attempted to get out of

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 _____	R 04/29/2016

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 323}	Continued From page 17	{F 323}		

w/c and independently ambulate. Res lost balance fell backwards and hit the back of her head..."
2/11/16- Progress note at 9:30 p.m. indicated, "Resident was attempting to get out of bed at 4:05 p.m. setting off TABS alarm and displaying behaviors of scratching, grabbing, hitting, and spitting with cares/ transfer provided. Received scheduled Ativan [anti-anxiety medication] with effectiveness noted..."
The QA [quality assurance) Post Fall investigation dated 2/11/16, at 11:04 a.m. indicated post fall interventions after the fall was to use the TABS alarm at all times, and educated activities to monitor resident more closely. There was no further investigation of the fall on 2/11/16, to determine if the resident was reclined in the tilt-in-space wheelchair, the residents behavior prior to the fall, and to ensure staff were educated R39 was to be in sight while up in the wheelchair.
4/20/16- The QA Post Fall investigation dated 4/20/16, at 6:28 a.m. indicated staff heard a TABS alarm sounding and went to R39's room and found the resident on the floor by the bathroom. The intervention put into place was 15 minute checks would be implemented. R39 received an abrasion to the left knee, and redness to both knees with redness that radiated down the left side of the leg. Staff had indicated R39 had been in bed prior to the fall.
The corresponding progress note dated 4/20/16, at 7:23 a.m. related to the fall earlier that morning indicated, "Heard an alarm sounding. Went to res room and found res lying on the floor near her bathroom. Res was attempting to crawl back towards her bed... Increase restlessness noted."
4/20/16- A QA Post Fall investigation dated 4/20/16, at 9:20 p.m. (a second fall on 4/20/16) indicated, "Resident noted to have eyes closed

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 _____	R 04/29/2016

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 323}	Continued From page 18 while in wheelchair in common area, when writer turned corner, writer heard TABS alarm sound and a thud. Resident noted to be on ground, on left side in fetal position." The interventions identified as having been in place prior to the fall were 15 minute checks, and TABS alarm. The interventions identified as put into place related to the fall included, "To be with staff when up in wheelchair." The notes indicated the resident was noted to have "abrasions" to the right knee, left shin, and left forehead. There was no further assessment of the fall to determine whether the wheelchair had been reclined at the time of the fall. In addition, although staff were directed to have R39 within staff sight while up in wheelchair since 2/10/16, this was not being implemented on 4/20/16. 4/24/16- A QA Post Fall investigation dated 4/24/16, at 2:30 p.m. indicated the resident had a fall from the tilt-in-space wheelchair, and received an 8 cm (centimeter) x 8 cm abrasion/ bump to right forehead, 8 cm skin tear to right arm, abrasions/ rug burns to right shoulder and bilateral knees. The notes indicated an intervention in place prior to the fall was for staff to have within eye sight while in wheelchair, and another for use of a TABS alarm. Post fall interventions identified for implementation after the fall included a request for possible OT orders for a different wheelchair. The QA Post Fall form indicated the resident had last been toileted on the day shift and the resident was having "behaviors" and staff was not able to toilet the resident on last rounds. The untitled internal investigation dated 4/24/16, indicated a NA was walking back towards R39 who was sitting by the table in the hallway when they witnessed the tilt-in-space wheelchair tipping forward. The note further indicated the resident	{F 323}		

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 _____	R 04/29/2016

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 323}	Continued From page 19 (R39) was lying face first on the ground with the tilt-in-space wheelchair leaning over the resident, and that R39's legs were tangled in the w/c foot pedals. The notes indicated the resident had been incontinent of urine at the time of the fall, and that she had also complained of pain. Progress notes dated 4/24/16, indicated the resident had been placed near the medication cart nurse or activities for increased supervision and for safety after the fall. "Resident appeared frightened after fall and quietly sitting in tilt-in-space w/c without any further attempts to self transfer... Daughter does have some concerns re: (regarding) recent falls and safety interventions for resident. Per daughter, will contact DON (director of nursing)/ RN (registered nurse) case manager Monday morning to discuss further interventions/ options for safety." Further review of R39's nursing progress notes dated 2/10- 4/25/16 revealed the following: 2/20/16- "Daughter is requesting the lap tray back so that she can have it on at all times so she can be safe and not fall and break a hip, and to have her independence with eating her snacks on it and having books and activities placed on it so she can do them herself. She is OK with waiting to discuss with DON on Monday to have one gotten." There was no documented evidence of any further discussion regarding R39's family request to have the lap tray placed back on her wheelchair. 2/29/16- "Have observed resident in tilt-in-space 6 times this week both reclined and up at the table. She appears comfortable each time." 3/5/16- "D/C scheduled Ativan. Ativan 2 mg/ ml [milliliters] intensol: give 0.25 mg Q [every] 3 hrs PRN anxiety." Although the facility discontinued the use of R39's antianxiety medication, the facility did not have any assessment/ plan to	{F 323}		

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 _____	R 04/29/2016

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 323}	Continued From page 20 ensure staff was monitoring R39 for increased anxiety, behaviors, and safety. 4/11/16- "Resident observed to swear and hit staff in stomach x 1 and kick staff in stomach x 2 at HS [hour of sleep] as staff initiating conversation with resident. Resident redirected to room and placed into bed. No further behaviors." 4/20/16- At 12:30 p.m. Resident was given PRN Ativan for, "Resident very anxious and trying to get out of wheelchair." Although the resident was anxious and attempting to get out of the wheelchair, there was no documented evidence regarding assessment for ongoing safety of the tilt-in-space wheelchair related to the resident's change in behavior and attempts to get out of the wheelchair. 4/20/16- At 10:03 p.m. the facility had received an order from the nurse practitioner (NP) to re-start Ativan twice daily 2 mg/ ml, 0.25 ml, and to continue the current PRN order; this is the same scheduled dose of Ativan that had been discontinued on 3/5/16. 4/21/16- 8:08 p.m. "Res became agitated and tried standing up when in dining room for music. Res taken back to Rosewood living room and given a snack at this time..." 4/22/16- 9:06 p.m. "Res noted to have increased restlessness this evening... Scheduled Ativan given as ordered." 4/23/16-3:55 p.m. Ativan given for "restlessness." 4/23/16- 9:32 p.m. "Resident noted to be striking out at other residents and attempting to self transfer from wheelchair...Resident again attempted to self transfer out of wheelchair during movie several times... Restlessness continues after snacks eaten. Resident taken for wheelchair ride off unit which she stated she enjoyed. Restlessness continues. PRN Ativan given which was effective."	{F 323}		

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 _____	R 04/29/2016

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 323}	Continued From page 21 4/23/16- 10:39 p.m. Ativan given for "Yelling loudly restless." 4/24/16- 1:31 p.m. "Resident dumping milk all over food, trying to move the table and get out of her chair... staff removed resident from dining room to redirect her and gave her a snack and scheduled pain med and resident calmed down." 4/24/16- 9:39 p.m. "Resident noted to be displaying behaviors of continuously attempting to get up off toilet on own with each toileting and during HS (bedtime)cares. Multiple and continuous cues and redirection to stay sitting provided with effectiveness." 4/25/16- 5:25 a.m. Resident was also attempting to get up walk and very anxious, combative striking out. Ativan given and was effective." 4/25/16- 9:53 a.m. Indicated the nurse manager had spoken with R39's daughter and informed her the resident was on 1 to 1 staffing, trialing a bedside table. The progress note also indicated, "Also discussed a tray table on the wheelchair." A physician progress note dated 3/4/16, indicated R39 had advanced dementia and had been discharged from hospice services on 2/10/16. That R39 had been receiving Ativan BID for history of physical aggression, and had also been receiving Morphine 5 times a day. The physician's progress note indicated the resident's anxiety had been stable, and the scheduled Ativan BID would be discontinued, however, the PRN Ativan every 3 hours would remain available if the resident would require it for anxiety. A physician progress note dated 4/20/16, indicated R39 was being seen for evaluation for increased, "Behavior," and staff had noted an increase in behaviors of hitting, kicking, and spitting out medications; all of which, "Put resident and staff at risk for injury." The Physician directed, "Had been stable on Ativan	{F 323}		

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 _____	R 04/29/2016

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 323}	Continued From page 22	{F 323}		

BID, this was stopped last month- since then she has become increasing restless as prior to Ativan use... Will resume Ativan 0.25 ml BID." Although the facility was aware of R39's increase in behaviors, restlessness, and attempts to get out of the wheelchair, no further assessment/ interventions had been initiated to ensure R39's safety when in the tilt-in-space wheelchair.

A physician progress note dated 4/25/16, indicated, "Staff report she had falls 4/20 x 2 and 4/24. [Increased] behaviors toward staff, [increased] restless and attempt to get out of wheelchair...She had been stable with hospice services, as a result hospice discharged her in February. At that time she was on Ativan BID and had a lap buddy for her w/c. She is also on morphine 10 mg five times a day...consider pain with [increased] restlessness, with dysphagia unable to order long acting morphine, will add fentanyl 25 mcg patch with morphine PRN pain." The Physician also indicated they would initiate an order for the resident to be evaluated for hospice services to resume.

R39's current physician orders dated 4/4/16, indicated the resident was utilizing the following medications:

- Ativan (antianxiety medication) 2 mg/ml, 0.25 ml every 3 hours PRN (as needed) for anxiety, with an original order date of 7/25/14.
- Ativan 2 mg/ ml, 0.25 ml twice a day, with a reorder date of 4/20/16.
- Fentanyl patch (pain medication) 25 mcg (micrograms) per hour- apply one patch every 72 hours, with an order date of 4/25/16.
- Roxanol (pain medication) 20 mg/ ml- 10 mg every 2 hours for pain and/ or restlessness, with an order date of 4/25/16.

R39's Medication administration records (MAR) for February- April 2016, indicated the resident

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 _____	R 04/29/2016

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 323}	Continued From page 23	{F 323}		

used no PRN Ativan in February or March 2016. In April 2016, R39 received PRN Ativan once on 4/20/16, twice on 4/23/16, and twice on 4/25/16. For the months of February and March 2016, R39 did not use any PRN Roxanol, however, in April 2016, the resident received one dose on 4/23/16, 4/24/16, and 4/25/16.

During interview on 4/26/16, at 1:00 p.m. family member (FM)-A stated she had been in contact with the facility multiple times regarding her concerns with R39's tilt and space wheelchair because she did not feel R39's current wheelchair (tilt and space) was safe, and had requested the facility to provide a safer wheelchair for the resident which included a lap tray, which had worked well for the resident in the past to prevent falls. FM-A stated recently the resident had some falls from the wheelchair, and the facility still had, "Done nothing," to ensure R39 was in a safe wheelchair. FM-A stated the resident had a history of being impulsive and getting out of the wheelchair and falling, and the facility had tried several different wheelchairs, a lap buddy, and a seat belt, however, hospice had initiated a lap tray about a year ago and R39 had no falls with that in place, and liked the tray because she was able to use it for snacks, and the resident didn't feel "restrained" in the chair. FM-A stated she was very concerned with the tilt-in-space wheelchair, and felt it was, "just a matter of time," before R39 figured out she was able to get out of the wheelchair, which she feels is what had occurred in the past week with the recent behaviors/ falls.

During interview on 4/26/16, at 2:20 p.m. registered nurse (RN)-A stated OT had determined the tilt-in-space wheelchair was appropriate for R39 and nursing did not have a safety assessment related to the tilt-in-space

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 _____	R 04/29/2016

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 323}	Continued From page 24	{F 323}		

wheelchair. RN-A was not aware of specific recommendations on how far R39 was to be reclined in the tilt-in-space wheelchair.
During observation on 4/26/16, from 2:42 p.m. to 2:47 p.m. R39 was sitting in the tilt-in-space wheelchair asleep in the hallway, reclined approximately 10 degrees. There were no staff anywhere around the resident, and no staff were able to visualize R39 while up in the wheelchair. Although the facility had identified on 4/25/16, the intervention to prevent further falls was to have the resident on 1-1, there were no staff with R39, nor was R39 within sight of any staff.

During interview on 4/26/16, at approximately 3:00 p.m. physical therapist (PT)-A stated OT was not in the building today. PT-A stated she was aware OT had received a request for an evaluation for R39's current wheelchair, however, R39 also had an order for a hospice evaluation, so OT would not be assessing the resident until it was determined if hospice would be starting services again.

During interview on 4/27/16, at 8:25 a.m. nursing assistant (NA)-B stated she worked for a staffing agency, however, she had worked with R39 in the past. R39 was laying in bed and NA-B was preparing to assist R39 with morning cares. R39 was attempting to sit up and get out of bed, and NA-B stated she needed to call for additional staff assistance because R39 was, "quick," and she could not turn her back on the resident or she would attempt to get out of bed and fall. NA-B called for additional assistance on the walkie talkie and continued to stand next to R39's bed to ensure R39 was not able to get out of bed. NA-B stated she was not aware of how far R39's wheelchair was to be tilted back, and she just

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 _____	R 04/29/2016

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 323}	Continued From page 25	{F 323}		

tilted it far enough back so the resident, "Would not fall out."
During interview on 4/27/16, at 8:30 a.m. NA-C stated staff were supposed to, "Keep an eye," on R39 when she was in the tilt and space wheelchair, and stated the resident was, "Quick and she tries to get up," out the wheelchair. NA-C stated there were no specific instructions on how far to tilt R39 back when she was in the wheelchair, and she just tilted the resident back far enough, "So she doesn't get out of the wheelchair." NA-C stated she believed R39 was to be checked on every 2 hours while in bed. NA-C was not aware R39 had a fall on 4/20/16, from bed and was not aware if any more frequent checks were to be completed when R39 was in bed.

During interview on 4/27/16, at 8:45 a.m. trained medication assistant (TMA)-A stated R39 received a tilt-in-space wheelchair in February 2016, and staff were instructed to ensure R39 was within staff sight when she was up in the wheelchair. TMA-A stated she was not aware of specific instructions on how far to recline R39's wheelchair, and all staff reclined the resident differently, however, she believed R39 should be reclined far enough to prevent her from getting out of the wheelchair. TMA-A stated the resident was quick, and when she was restless in the wheelchair, staff needed to be close to her and ensure the resident was reclined enough so she didn't fall out. TMA-A stated she was working on 4/20/16, when R39 had the fall in the morning out of bed. TMA-A was not aware if any further interventions were put into place for the fall, and she felt this was a, "One time thing," so she did not think more frequent checks were implemented, even with the recent behavior and

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 _____	R 04/29/2016

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 323}	Continued From page 26	{F 323}		

medication changes. TMA-A stated R39 had a change in behavior and increase in falls in the past couple weeks, both from the wheelchair and the bed and was not sure why, however, she stated there had been a lot of changes in medication, and hospice care had been discontinued in February 2016, and she thought the resident was, "missing the attention," she had received from hospice.

During interview on 4/27/16, at 10:05 a.m. occupational therapist (OT)-A stated she had worked with R39 from 2/10/16, to 3/4/16, to fit the resident for a new wheelchair. OT-A stated she had not directed staff on how far R39 should be tilted back in the tilt-in-space wheelchair, and she was not aware of R39's recent falls from the tilt-in-space wheelchair until today, 4/27/16. OT-A stated she was aware R39 had a fall from the tilt and space wheelchair on 2/11/16, and thought the resident was not reclined in the wheelchair, and staff had left the resident alone, however, OT-A stated she did not give staff recommendations on how far to tilt the resident back in the wheelchair but just enforced R39 needed to be within staff sight at all times when up in the wheelchair. OT-A stated she had educated nursing staff on 2/10/16, that while R39 was in the tilt-in-space wheelchair, staff needed to have the resident within their sight at all times. OT-A stated she was not aware R39 had been recently attempting to get out of the tilt-in-space wheelchair and had a change in behavior and medications, and staff should have notified her immediately to re-evaluate the safety of the wheelchair. OT-A stated staff had spoken to her this morning and asked that she re-evaluate the wheelchair as hospice would not be seeing the resident until later in the week and "state" had concerns with

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 _____	R 04/29/2016

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 323}	Continued From page 27	{F 323}		

the safety of the tilt-in-space wheelchair. OT-A stated the expectation was for nursing to do ongoing monitoring for safety of any new device that was implemented.

During interview on 4/27/16, at 12:37 p.m. consultant nurse (CN) stated R39's case manager did the investigations for the recent change in behaviors and falls, however, she was not currently working, and she would need to contact her to see where the information was located. CN stated she believed R39 was currently on a 1-1 with staff since 4/25/16, which meant a specific staff member was to be with R39 at all times when in her wheelchair. CN stated the facility was waiting for hospice to come and evaluate R39, however, she had spoken to OT earlier and directed a assessment needed to be completed on R39's wheelchair today. CN stated staff knew about the intervention of having R39 within sight when up in wheelchair since it was implemented on 2/10/16, however, this was not being followed on 2/11/16, or on the fall the evening of 4/20/16. CN stated the communication to staff would be in the nursing communication book. When CN reviewed the communication book she verified there was no communication to staff regarding direction to ensure R39 was within staff sight while up in the wheelchair.

During interview on 4/27/16, at 3:31 p.m. licensed practical nurse (LPN)-A stated R39 had a recent increase in behaviors and falls from the wheelchair. LPN-A was not aware of specific recommendations on how far R39 should be reclined in the wheelchair. LPN-A stated since the increase in falls, R39 was on 15 minute checks, and should be within line sight of staff

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 _____	R 04/29/2016

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 323}	Continued From page 28	{F 323}		

when up in the wheelchair. LPN-A stated R39 was "quick" and would be sleeping in the wheelchair one minute, and you would turn your back and she would then be attempting to get out of the wheelchair. LPN-A stated staff were not doing a "true 1-1" right now, as that would be a staff sitting with the resident at all times, and they didn't have the staff to do that.

During interview on 4/27/16, at 3:37 p.m. NA-D stated R39's wheelchair was to be upright during meals, but there was no specific direction on how far to tilt the resident back. NA-D stated, "Since she started falling," staff had been directed to ensure the resident is within sight of staff. NA-D stated it was a "challenge" to keep her within sight because staff need to assist other residents, and they cant bring R39 into other resident rooms with them. NA-D stated R39 was "unpredictable," and one minute she would be sleeping in the wheelchair, and the next minute she would be attempting to get out of the wheelchair.

During interview on 4/27/16, at 3:42 p.m. NA-E stated R39 was to be sitting straight up at meals but there was no specific direction on how far to recline the resident in the wheelchair. NA-E stated since R39 "started falling" staff were directed to keep her in their line of sight, and this was not started until last week. NA-E stated they weren't aware of anything different staff were doing for R39, but stated, "We started doing 1-1 the day you guys [state] came in."

During a follow up interview on 4/27/16, at 5:09 p.m. LPN-A stated she had recently been directed R39 was to be a "1-1," however, she stated that was "impossible" as staff had other residents to

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 _____	R 04/29/2016

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 323}	Continued From page 29	{F 323}		

take care of, and when she was administering medication to other residents she could not take R39 into a room with her. LPN-A stated the resident was currently in an activity. At that time LPN-A walked to the day room where she believed the activity was taking place, and R39 was sitting alone in the tilt-in-space wheelchair not reclined with a lap tray on that folded down on both sides, and no staff or residents were around or within sight of R39. LPN-A stated she did not know how long R39 had been left alone, and no one had let her know the activity was completed. LPN-A stated OT had just implemented the lap tray on R39's wheelchair "about an hour ago," and directed staff if the resident was sitting any higher then 45 degrees, the lap tray should be on. LPN-A attempted to recline the wheelchair back to 45 degrees and stated, "She is leaning back way to far like that; she is almost upside down." LPN-A brought R39 to the medication cart, and stated she would "try" to keep her eye on the resident as much as possible.

During a phone interview on 4/28/16, at 8:30 a.m. FM-A stated she had been at the facility last evening with R39 and had concerns regarding the lap tray the facility had just put into place. FM-A stated when she arrived at the facility last evening, R39 was sitting alone in the day room by the bird aviary, and was lifting up both sides of the lap tray. FM-A stated she told staff last evening R39 was able to lift up the lap tray and she was worried the resident would fall out of the wheelchair because she was not reclined at all in the wheelchair when they had the lap tray in place.

Review of R39's progress notes from 4/27/16, at 11:47 p.m. indicated, "Resident made serveral

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 _____	R 04/29/2016

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 323}	Continued From page 30	{F 323}		

attempts to self transfer out of wheelchair. Resident did fold both sides of tray table to the side to aide in her self transferring from wheelchair..."

During follow up interview on 4/28/16, at 9:00 a.m. OT stated staff told her this morning that R39 was, "restless and up late last night," so she was waiting for the resident to wake up to assess R39's ability to eat with the new lap tray in place. OT stated staff had not made her aware R39 was lifting up the lap tray last evening attempting to get out of the wheelchair, and this should have been communicated to her as the lap tray may not be safe for R39 and should be reassessed. OT stated she was aware it was not "realistic" for staff to have R39 within eye sight at all times, however, during her assessment the facility was concerned with using any device that would be considered a restraint. OT stated nursing and therapy needed to improve communication to ensure resident safety, especially with significant medication changes or changes in behaviors.

During phone interview on 4/28/16, at 12:45 p.m. RN-B (who was R39's case manager) stated she had completed all of R39 fall assessments and implemented interventions. RN-B stated after the fall in the morning on 4/20/16, R39 was put on 15 minute checks while in bed for 24 hours, and staff were to log what the resident was doing and her behaviors, and report back to RN-B to determine further interventions. RN-B stated she was not provided the information from staff, so no further assessment had been completed. RN-B stated she had not followed up with staff because she was, "Off work the next day." She also stated she was in the process of disciplining a night shift staff due to the morning fall on 4/20/16, because

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 _____	R 04/29/2016

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 323}	Continued From page 31	{F 323}		

staff, "Should have gotten to her [R39] sooner." However, the discipline had not been documented or completed as RN-B had, "Not seen her [the NA] yet." Regarding the fall the evening of 4/20/16, RN-B stated she was disciplining 3 staff related to not following the care plan and having R39 in their sight while in the wheelchair, which had not been documented or completed yet. RN-B stated after the fall, R39 was put on 1-1 for 24 hours, which was discontinued on 4/21/16, however, RN-B stated she did no further assessment related to the fall, interventions currently in place, or the safety of the wheelchair. Regarding the fall on 4/24/16, RN-B stated she did not have a full investigation of the fall, "because I wasn't working at that time." RN-B stated R39 had no current safety assessment that was documented, however, she stated she had completed one but didn't document it. RN-B stated there was no assessment regarding the recent change in resident behaviors, safety of the tilt-in-space wheelchair, medication change response, if current interventions were being implemented and were adequate, and if further interventions needed to be implemented. RN-B stated she was not aware R39 had recently (4/20/16) been started on scheduled Ativan BID, and stated that had not been part of her assessment when looking at the falls and change in behavior.

Although the facility's policies regarding resident falls were requested, none were provided.
The IJ identified on 4/28/16, at 1:31 p.m. was removed on 4/29/16, at 5:24 p.m. after the facility completed the following interventions as part of their removal plan:
- The facility implemented 1:1 staffing to be with R39 for 24 hours while up in the wheelchair, and

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 _____	R 04/29/2016

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 323}	Continued From page 32 then would be reassessed by nursing for ongoing need. OT fitted R39 for a different wheelchair with a full, attached lap tray and assessed the resident was safe. Root cause analysis was done for all prior falls, 30 minute checks were implemented while in bed, a sleep study was started, medication review was completed by the pharmacist and physician, and assessments were completed included pain, fall risk, safety, restraint, head to toe, and bowel and bladder. R39's care plan was updated to include specific instructions on the current wheelchair and lap tray use, R39 was provided a sensory activity basket to decrease agitation, staff were directed if R39 becomes agitated to attempt specific non-pharmacological approach's. All staff were educated on new care plan interventions for R39, as well as how to utilize the wheelchair and lap tray. An audit of all resident will be conducted to identify potential triggers for elevated risk of falls, a fall report checklist was developed for staff, and a representative from therapy department will be present at the daily interdisciplinary meeting to ensure nursing and therapy are communicating. In addition, on 4/29/16, from 3:55 p.m. to 5:00 p.m. NA's, RN's, case managers, activity staff, OT, and TMA's were interviewed and confirmed they had received education regarding R39's wheelchair and new fall interventions that had been put into place.	{F 323}		
{F 520} SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the	{F 520}		5/18/16

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 _____	R 04/29/2016

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 520}	Continued From page 33 facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Quality Assessment (QA) committee recognized and developed action plans to address neglect of care and potential for injury for 1 of 1 resident (R39) who had multiple falls with injury and potential for serious injury. Also, the QA committee failed to develop an action plan to address an identified lack of comprehensive assessment for use of restraint devices to ensure the least restrictive intervention. In addition, the QA committee failed to develop an action plan to address an identified lack of timely reporting of potential abuse and neglect to the State agency. These deficient practices had potential to affect all 64 residents in the facility.	{F 520}	F520 It is the policy of Talahi to conduct a Quality Assurance Performance Improvement (QAPI) meeting monthly which is attended by the QAPI Committee. Falls, Abuse Prevention, Vulnerable Adult and any Variances are reviewed by the committee and action plans are developed to address identified areas of need and concern. On April 29, 2016 there was a Quality Assurance Performance Improvement meeting to discuss actions implemented to continue to assure safety for R39. The audit conducted to identify potential triggers for elevated risk of falls was also	

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 _____	R 04/29/2016

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 520}	Continued From page 34 Findings include: See F221 as the facility failed to ensure physical restraints were comprehensively assessed to ensure staff were aware of specific direction on how to utilize the restraint, as well to ensure resident safety for 1 of 1 resident (R39) reviewed who utilized a restraint. See F225 as the facility failed to ensure allegations of neglect were immediately reported to the state agency for 2 of 7 residents (R39 and R68). See F226 as the facility failed to implement abuse policies and procedures related to immediate reporting of allegations of neglect to the state agency for 2 of 7 residents (R39 and R68), who had allegations of staff neglect. See F323 as the facility failed to ensure resident falls were comprehensively assessed and interventions were implemented to prevent falls for 1 of 3 resident (R39) reviewed with falls. This resulted in an immediate jeopardy for R39. On 4/29/16, at 5:30 p.m., the director of nursing and administrator were interviewed regarding the facilities' Quality Assessment and Assurance (QA&A) program. The DON stated the QA committee had met twice since the recertification survey in 2/16, and although they had discussed the survey results, they, "Didn't go through them individually." Although the lack of timely reporting related to their vulnerable adult and abuse reports had been identified as a concern, an action plan had never been developed to address how to resolve the issue by the QA committee. DON	{F 520}	discussed. The QAPI policy and procedure was reviewed and was determined complete and current. QAPI meeting minutes will be recorded on a specific format to assure documentation of action plans developed by the QAPI committee. The QAPI agenda shall contain on-going audits of F-tags issued during the 2016 survey, to assess for on-going compliance. DON/Designee, Administrator Responsible.	

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 _____	R 04/29/2016

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 520}	Continued From page 35 indicated she had presented a summary of how many vulnerable adult and abuse reports had been filed within the month, but stated she, "Didn't get specific as to the day, just that they were reported." In addition, although the lack of comprehensive assessment for use of restraint devices had been identified as a concern, DON stated she didn't recall talking about restraints during the QA committee meetings. An undated facility Quality Assessment / Assurance Plan policy identified several objectives of the QA&A committee including, "Assist individual department's staff to improve resident care, to monitor and to evaluate departmental activities and services," and, "Evaluate the results of actions taken by individual departments and maximize the efficient use of resources available within the Facility and the community." The policy indicated, "The Quality Assessment/Assurance Committee is responsible for assuring that activities are directed toward the continuous improvement of care," which included a bulleted list identifying, "Appropriate actions are implemented to eliminate or reduce identified problems or otherwise improve care to the greatest degree reasonable [sic] possible."	{F 520}		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245438 Y1	A. Building B. Wing Y2	4/29/2016 Y3

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0159	Correction	ID Prefix F0221	Correction	ID Prefix F0224	Correction
Reg. # 483.10(c)(2)-(5)	Completed	Reg. # 483.13(a)	Completed	Reg. # 483.13(c)	Completed
LSC	02/29/2016	LSC	02/29/2016	LSC	03/18/2016
ID Prefix F0241	Correction	ID Prefix F0242	Correction	ID Prefix F0250	Correction
Reg. # 483.15(a)	Completed	Reg. # 483.15(b)	Completed	Reg. # 483.15(g)(1)	Completed
LSC	03/04/2016	LSC	03/04/2016	LSC	03/09/2016
ID Prefix F0257	Correction	ID Prefix F0279	Correction	ID Prefix F0282	Correction
Reg. # 483.15(h)(6)	Completed	Reg. # 483.20(d), 483.20(k)(1)	Completed	Reg. # 483.20(k)(3)(ii)	Completed
LSC	03/01/2016	LSC	03/04/2016	LSC	02/29/2016
ID Prefix F0309	Correction	ID Prefix F0311	Correction	ID Prefix F0312	Correction
Reg. # 483.25	Completed	Reg. # 483.25(a)(2)	Completed	Reg. # 483.25(a)(3)	Completed
LSC	02/29/2016	LSC	03/04/2016	LSC	03/04/2016
ID Prefix F0314	Correction	ID Prefix F0329	Correction	ID Prefix F0353	Correction
Reg. # 483.25(c)	Completed	Reg. # 483.25(l)	Completed	Reg. # 483.30(a)	Completed
LSC	03/04/2016	LSC	03/18/2016	LSC	03/11/2016

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	JS/KJ	05/13/2016	32208	04/29/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245438 Y1	A. Building B. Wing Y2	4/29/2016 Y3

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0367	Correction	ID Prefix F0425	Correction	ID Prefix F0428	Correction
Reg. # 483.35(e)	Completed	Reg. # 483.60(a),(b)	Completed	Reg. # 483.60(c)	Completed
LSC	03/04/2016	LSC	03/11/2016	LSC	03/11/2016
ID Prefix F0441	Correction	ID Prefix F0490	Correction	ID Prefix F0497	Correction
Reg. # 483.65	Completed	Reg. # 483.75	Completed	Reg. # 483.75(e)(8)	Completed
LSC	02/29/2016	LSC	03/11/2016	LSC	03/18/2016
ID Prefix F0501	Correction	ID Prefix F0522	Correction		
Reg. # 483.75(i)	Completed	Reg. # 483.75(p)	Completed		
LSC	03/04/2016	LSC	02/18/2016		

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	JS/KJ	05/13/2016	32208	04/29/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
2/1/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245438 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	5/16/2016 Y3

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0046	03/25/2016	LSC K0050	03/25/2016	LSC K0052	03/25/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0054	03/25/2016	LSC K0062	03/25/2016	LSC K0066	03/25/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0067	03/25/2016	LSC K0144	03/25/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	PK/KJ	06/17/2016	35575	05/16/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
1/26/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: ENWF

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 **02/01/2016** (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:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	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 :
Austin Fry, HFE NE II — 03/07/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 03/10/2016 (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
Posted 03/10/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically Submitted
February 16, 2016

Mr. George Paulson, Administrator
Talahi Nursing & Rehab Center
1717 University Drive Southeast
Saint Cloud, Minnesota 56304

RE: Project Number S5438027, and Complaints Numbered H5438042 & H5438043

Dear Mr. Paulson:

On February 1, 2016, an extended survey was completed at your facility by the Minnesota Department 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. In addition, at the time of the February 1, 2016 extended survey the Minnesota Department of Health completed an investigation of complaint number H5438043 which was substantiated at F311, F353, F367.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered. In addition, at the time of the February 1, 2016 extended survey the Minnesota Department of Health completed an investigation of complaint number H5438042 that was found to be unsubstantiated.

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

Removal of Immediate Jeopardy - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

Substandard Quality of Care - means one or more deficiencies related to participation

requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Potential Consequences - the consequences of not attaining substantial compliance 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.

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on February 1, 2016, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

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
Licensing & Certification
Health Regulation Division
Midtown Square
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7343
Fax: (320)223-7348

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

- State Monitoring effective February 22, 2016. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F224 (S/S=G), effective January 16, 2015. (42 CFR 488.430 through 488.444)

- Civil money penalty for the deficiency cited at F323 (S/S=J), effective January 28, 2016. (42 CFR 488.430 through 488.444)

- Mandatory Denial of Payment for new Medicare and Medicaid admissions effective May 1, 2016

The CMS Region V Office will notify you of their determination regarding our recommendations and your appeal rights.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Talahi Nursing And Rehab Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs

for two years effective February 1, 2016. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

• 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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. 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.

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 May 1, 2016 (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 August 1, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
Email: tom.linhoff@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Midwest Division of Survey and Certification
Chicago Regional Office
233 North Michigan Avenue, Suite 600
Chicago, IL 60601-5519

CMS Certification Number (CCN): 245438

February 23, 2016
By Certified Mail and Facsimile

Mr. George Paulson, Administrator
Talahi Nursing and Rehab Center
1717 University Drive Southeast
Saint Cloud, MN 56304

Dear Mr. Paulson:

SUBJECT: FEDERAL MONITORING SURVEY RESULTS AND NOTICE OF IMPOSITION OF REMEDIES
Cycle Start Date: February 1, 2016

STATE SURVEY RESULTS
On January 26, 2016, a Life Safety Code survey and on February 1, 2016, a health survey were completed at Talahi Nursing and Rehab Center by the Minnesota Department of Health (MDH) to determine if your facility was in compliance with the Federal requirements for nursing homes participating in the Medicare and Medicaid programs. These surveys found that your facility was not in substantial compliance, with the most serious deficiency to place the health and safety of your residents in immediate jeopardy. This deficiency was cited at scope and severity (S/S) level J, as follows:

- F323 -- S/S: J -- 483.25(h) -- Free Of Accident Hazards/supervision/devices.

In addition, the above cited deficiency constitutes substandard quality of care (SQC) and an extended survey was performed.

Surveyors found a situation of immediate jeopardy to resident health and safety that began January 28, 2016 and was removed February 1, 2016. However, they also found that your facility continues to be not in substantial compliance with Federal requirements as a result of uncorrected deficiencies:

- F159 -- S/S: E -- 483.10(c)(2)-(5) -- Facility Management Of Personal Funds
- F221 -- S/S: D -- 483.13(a) -- Right To Be Free From Physical Restraints
- F224 -- S/S: G -- 483.13(c) -- Prohibit Mistreatment/neglect/misappropriatn
- F225 -- S/S: E -- 483.13(c)(1)(ii)-(iii), (c)(2) - (4) -- Investigate/report Allegations/individuals
- F226 -- S/S: E -- 483.13(c) -- Develop/implment Abuse/neglect, Etc Policies
- F241 -- S/S: D -- 483.15(a) -- Dignity And Respect Of Individuality
- F242 -- S/S: D -- 483.15(b) -- Self-Determination - Right To Make Choices
- F250 -- S/S: D -- 483.15(g)(1) -- Provision Of Medically Related Social Service
- F257 -- S/S: D -- 483.15(h)(6) -- Comfortable & Safe Temperature Levels
- F279 -- S/S: D -- 483.20(d), 483.20(k)(1) -- Develop Comprehensive Care Plans

- F282 -- S/S: D -- 483.20(k)(3)(ii) -- Services By Qualified Persons/per Care Plan
- F309 -- S/S: D -- 483.25 -- Provide Care/services For Highest Well Being
- F311 -- S/S: E -- 483.25(a)(2) -- Treatment/services To Improve/maintain Adls
- F312 -- S/S: D -- 483.25(a)(3) -- Adl Care Provided For Dependent Residents
- F314 -- S/S: D -- 483.25(c) -- Treatment/svcs To Prevent/heal Pressure Sores
- F329 -- S/S: D -- 483.25(l) -- Drug Regimen Is Free From Unnecessary Drugs
- F353 -- S/S: F -- 483.30(a) -- Sufficient 24-Hr Nursing Staff Per Care Plans
- F367 -- S/S: D -- 483.35(e) -- Therapeutic Diet Prescribed By Physician
- F425 -- S/S: D -- 483.60(a),(b) -- Pharmaceutical Svc - Accurate Procedures, Rph
- F428 -- S/S: E -- 483.60(c) -- Drug Regimen Review, Report Irregular, Act On
- F441 -- S/S: F -- 483.65 -- Infection Control, Prevent Spread, Linens
- F490 -- S/S: D -- 483.75 -- Effective Administration/resident Well-Being
- F497 -- S/S: F -- 483.75(e)(8) -- Nurse Aide Perform Review-12 Hr/yr Inservice
- F501 -- S/S: D -- 483.75(i) -- Responsibilities Of Medical Director
- F520 -- S/S: F -- 483.75(o)(1) -- QAA Committee-Members/meet Quarterly/plans

The State agency advised you of the deficiencies that led to this determination and provided you with a copy of the survey reports (CMS-2567).

FEDERAL MONITORING SURVEY
In addition, a surveyor representing this office of the Centers for Medicare & Medicaid Services (CMS) completed a Federal Monitoring Survey (FMS) of your facility on February 9, 2016. As the surveyor informed you during the exit conference, the FMS has revealed that your facility continues to not be in substantial compliance. The FMS found deficiencies, with the most serious being at S/S level F, at the following tags:

- K46 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K48 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K50 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K52 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K54 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K62 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K144 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K154 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K155 -- S/S: F -- NFPA 101 -- Life Safety Code Standard

The findings from the FMS on form CMS-2567 will be posted on the ePOC system.

ELECTRONIC PLAN OF CORRECTION (ePOC)
Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the enclosed deficiencies cited at the FMS. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation.

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

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

INFORMAL DISPUTE RESOLUTION
The State agency offered you an opportunity for informal dispute resolution (IDR) following its survey visits. A request for IDR will not delay the effective date of any enforcement action. However, IDR results will be considered when applicable.

CMS has established an IDR process to give providers one opportunity to informally refute deficiencies cited at a Federal survey, in accordance with the regulation at 42 CFR §488.331. To use this process, you must send your written request, identifying the specific deficiencies you are disputing to, Stephen Pelinski, Survey Branch Manager, at the Chicago address or by email at Stephen.Pelinski@cms.hhs.gov. The request must set forth in detail your reasons for disputing each deficiency and include copies of all relevant documents supporting your position. A request for IDR will not delay the effective date of any enforcement action, nor can you use it to challenge any other aspect of the survey process, including the following:

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

You must submit your request for IDR within the same ten (10) calendar day timeframe for submitting your ePOC. You must provide an acceptable ePOC for all cited deficiencies, including those that you dispute. We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)
In accordance with 42 CFR §488.431, when a civil money penalty subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies from the February 1, 2016 survey through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. To be given such an opportunity, 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 (or why you are disputing the scope and severity assessments of deficiencies which have been found to constitute SQC or immediate jeopardy) to www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm.

This request must be sent within 10 calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR §488.431, when a civil money penalty subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies resulting from the FMS through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. To be given such an opportunity, you are required to send your written request to Jan Suzuki, at the Chicago address or by electronic mail to Jan.Suzuki@cms.hhs.gov with an electronic copy of the request sent to CMSQualityAssurance@cms.hhs.gov and Michele.Laughman@cms.hhs.gov. The documents along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies (or why you are disputing the scope and severity assessments of deficiencies which have been found to constitute actual harm or immediate jeopardy) should be sent to:

Anita Makkenchery
Catapult Consultants, LLC
1300 North 17th Street, Suite 700
Arlington, VA 22209
Phone: 703-849-0960 x125 Fax: 703-997-0086
Email: AMakkenchery@catapultconsultants.com

Please send a copy of your documents to Jan Suzuki. This request must be sent within 10 calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

IDR and Independent IDR in no way are to be construed as a formal evidentiary hearing. They are informal administrative processes to discuss deficiencies. You will be advised verbally of our decision relative to the informal dispute, with written confirmation to follow.

LIFE SAFETY CODE (LSC) WAIVERS

If you request an annual waiver for a LSC deficiency cited during the FMS, the request must indicate why correcting would impose an unreasonable hardship on the facility; if high cost is the hardship, you must include recent, bona fide cost estimates. In addition, the request must indicate how continued non-correction of the deficiency will not pose a risk to resident safety, based on additional compensating features or other reasons.

Each cited deficiency (other than those which receive annual waivers) must be corrected within a reasonable timeframe. If a reasonable correction date falls beyond your enforcement cycle's three month date, you may request a temporary waiver to allow correction by the reasonable date, and without the noncompliance leading to the imposition of remedies. Include a request for a temporary waiver as part of your POC, indicating the basis for the length of correction time needed, and include a timetable for correction. A temporary waiver may be granted if the POC date extends beyond your enforcement cycle's three month date, and if the correction timeframe is reasonable, in CMS' judgment. Your enforcement cycle's three month date is May 1, 2016.

SUMMARY OF ENFORCEMENT REMEDIES
As a result of the survey findings, and as authorized by the Centers for Medicare & Medicaid Services (CMS), the MDH notified you on February 16, 2016 of the imposition of the following remedy:

- State Monitoring effective February 22, 2016

The State survey agency notified you they were recommending that the CMS impose additional remedies. We concur with the State's recommendation and are imposing the following remedies:

- Federal Civil Money Penalty of $4,800.00 per day for the four (4) days beginning January 28, 2016 and continuing through January 31, 2016 for a total of $19,200.00
- Federal Civil Money Penalty of $250.00 per day beginning February 1, 2016
- Mandatory Denial of Payment for New Medicare and Medicaid Admissions effective May 1, 2016

The authority for the imposition of remedies is contained in 1819(h) and 1919(h) of the Social Security Act ("Act") and Federal regulations at 42 CFR §488, Subpart F, Enforcement of Compliance for Long-Term Care Facilities with Deficiencies.

DENIAL OF PAYMENT FOR NEW ADMISSIONS
Mandatory denial of payment for all new Medicare admissions is imposed effective May 1, 2016 if your facility does not achieve compliance within the required three months. This action is mandated by the Act at Sections 1819(h)(2)(D) and 1919 (h)(2)(C) and Federal regulations at 42 CFR § 488.417(b). We will notify National Government Services that the denial of payment for all new Medicare admissions is effective on May 1, 2016. We are further notifying the State Medicaid agency that they must also deny payment for all new Medicaid admissions effective May 1, 2016.

You should notify all Medicare and Medicaid residents admitted on or after this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new Medicare admissions includes Medicare beneficiaries enrolled in managed care plans. It is your obligation to inform Medicare managed care plans contracting with your facility of this denial of payment for new admissions.

CIVIL MONEY PENALTY
In determining the amount of the Civil Money Penalty (CMP) that we are imposing for each day of noncompliance, we have considered your facility's history, including any repeated deficiencies; its financial condition; and the factors specified in the Federal requirement at 42 CFR §488.404. We are imposing the following CMP:

- Federal Civil Money Penalty of $4,800.00 per day for the four (4) days beginning January 28, 2016 and continuing through January 31, 2016 for a total of $19,200.00
- Federal Civil Money Penalty of $250.00 per day beginning February 1, 2016

The CMP continues to accrue at the amount of $250.00 per day until you have made the necessary corrections to achieve substantial compliance with the participation requirements, or your provider agreement is terminated. However, the amount of the CMP may be increased or decreased if we find that the noncompliance changes.

If you believe that you have documented evidence that should be considered in establishing the amount of the CMP, the following documents should be submitted to this office within fifteen (15) days from the receipt of this notice:

- Written, dated request specifying the reason financial hardship is alleged
- List of the supporting documents submitted
- Current balance sheet
- Current income statements
- Current cash flow statements
- Most recent full year audited financial statements prepared by an independent accounting firm, including footnotes
- Most recent full year audited financial statements of the home office and/or related entities, prepared by an independent accounting firm, including footnotes
- Disclosure of expenses and amounts paid/accrued to the home office and/or related entities
- Schedule showing amounts due to/from related companies or individuals included in the balance sheets. The schedule should list the names of related organizations or persons and indicate where the amounts appear on the balance sheet (e.g., Accounts Receivable, Notes Receivable, etc.)
- If the nursing home requests an extended payment schedule of more than twelve (12) months duration, the provider must submit a letter from a financial institution denying the provider's loan request for the amount of the CMP

The CMP is due and payable and may be placed in escrow account fifteen days after one of the following, whichever occurs first:

- The date on which an Independent IDR process is completed, if applicable or
- The date which is 90 calendar days after the date of the notice of imposition of the civil money penalty.

CMP REDUCED IF HEARING WAIVED

If you waive your right to a hearing, **in writing**, within 60 calendar days from receipt of this notice, the amount of your CMP will be reduced by thirty-five percent (35%). To receive this reduction, the written waiver should be sent to the Centers for Medicare & Medicaid Services, Division of Survey and Certification, 233 North Michigan Avenue, Suite 600, Chicago, Illinois 60601-5519. **The failure to request a hearing within 60 calendar days from your receipt of this notice does not constitute a waiver of your right to a hearing for purposes of the 35% reduction.**

Any subsequent survey that results in a finding of continued noncompliance may affect the CMP. If, based on the new finding, the previously imposed CMP amount is continued or the CMP amount is changed, and you choose not to accept the new finding, it will be necessary for you to submit an additional request for a hearing on the subsequent survey finding. Alternatively, you may submit a written waiver of your right to a hearing on the subsequent survey finding.

A CMP case number will be assigned to your case only when the final CMP is due and payable. At that time you will receive a notice from this office with the CMP case number and payment instructions. Prior to the assignment of a CMP case number, you must ensure that your facility's name, Your CMS Certification Number (CCN), and the enforcement cycle start date appear on any correspondence pertaining to this CMP.

- Your CMS Certification Number (CCN) is 245438.
- The start date for this cycle is February 1, 2016.

TERMINATION PROVISION
If your facility has not attained substantial compliance by August 1, 2016, your Medicare and Medicaid participation will be terminated effective with that date. This action is mandated by the Act at §§ 1819(h) and 1919(h) and Federal regulations at 42 CFR § 488.456 and §489.53.

We are required to provide the general public with notice of an impending termination and will publish a notice in a local newspaper prior to the effective date of termination. If termination goes into effect, you may take steps to come into compliance with the Federal requirements for long term care facilities and reapply to establish your facility's eligibility to participate as a provider of services under Title XVIII of the Act. Should you seek re-entry into the Medicare program, the Federal regulation at 42 CFR §489.57 will apply.

NURSE AIDE TRAINING PROHIBITION
Please note that Federal law, as specified in the Act at 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a §1819(b)(4)(C)(ii)(II) or §1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $5,000.00; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities..

Because the facility was subject to an extended survey, this provision is applicable to your facility. Therefore, Talahi Nursing and Rehab Center is prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 1, 2016. You will receive further information regarding this from the State agency. Further, this prohibition remains in effect for the specified period even though selected remedies may be rescinded at a later date if your facility attains substantial compliance. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

APPEAL RIGHTS
The State survey agency previously advised of your right to appeal the noncompliance that resulted in the finding of SQC which resulted in the loss of NATCEP approval. Please refer to that notice and note the deadline for that appeal. As of this date, we have not received a request for a hearing.

This formal notice imposed:

- Mandatory Denial of Payment for New Medicare and Medicaid Admissions effective May 1, 2016
- Civil Money Penalty effective January 28, 2016

If you disagree with the findings of noncompliance which resulted in this imposition, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in Federal regulations at 42 CFR §498.

You are required to file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at https://dab.efile.hhs.gov/. To file a new appeal using DAB EFile, you first need to register a new account by: (1) clicking Register on the DAB E-File home page; (2) entering the information requested on the "Register New Account" form; and (3) clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user's access to DAB EFile is restricted to the appeals for which he is a party or authorized representative. Once registered, you may file your appeal by:

- Clicking the **File New Appeal** link on the Manage Existing Appeals screen, then clicking **Civil Remedies Division** on the File New Appeal screen.
- Entering and uploading the requested information and documents on the "File New Appeal- Civil Remedies Division" form.

At minimum, the Civil Remedies Division (CRD) requires a party to file a signed request for hearing and the underlying notice letter from CMS that sets forth the action taken and the party's appeal rights. A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree, including a finding of substandard quality of care, if applicable. It should also specify the basis for contending that the findings and conclusions are incorrect. The DAB will set the location for the hearing. Counsel may represent you at a hearing at your own expense.

All documents must be submitted in Portable Document Format ("PDF"). Any document, including a request for hearing, will be deemed to have been filed on a given day, if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day. A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the Administrative Law Judge, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service. More detailed instructions for using DAB E-File in cases before the DAB's Civil Remedies Division can be found by clicking the button marked **E-Filing Instructions** after logging-in to DAB E-File.

For questions regarding the E-Filing system, please contact E-File System Support at **OSDABImmediateOffice@hhs.gov**.

Please note that **all** hearing requests must be filed electronically unless you have no access to the internet or a computer. In those circumstances, you will need to provide an explanation as to why you are unable to file electronically and request a waiver from e-filing with your written request. Such a request should be made to:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Nancy K. Rubenstein, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, D.C. 20201

A request for a hearing must be filed no later than 60 days from the date of receipt of this notice.

It is important that you send a copy of your request to our Chicago office to the attention of Jan Suzuki. Failure to do so could result in our office proceeding with collection of the CMP.

CONTACT INFORMATION
If you have any questions regarding the Federal Monitoring LSC survey, please contact Joseph Frye, Nurse Consultant, Health & Life Safety Specialist, at (312) 886-2567. Joseph Frye's fax number is (443) 380-6577. For questions regarding this enforcement case, please contact Jan Suzuki, Program Representative, at (312) 886-5209. Information may also be faxed to (443) 380-6602.

Sincerely,

/s/

Steven Delich
Acting Branch Manager
Long Term Care Certification
& Enforcement Branch

cc: Minnesota Department of Health
Minnesota Department of Human Services
Office of Ombudsman for Older Minnesotans
Stratis Health

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 _____	02/01/2016

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 A survey was conducted by the Minnesota Department of Health on 1/25/16- 2/1/16. The survey resulted in an Immediate Jeopardy (IJ) at F323 related to the facility's failed response when the resident consumed alcohol and became intoxicated, and put himself and others at significant risk for serious injury. The IJ began on 1/28/16, at 5:58 p.m., when it was identified the residents safety was at immediate risk due to multiple incidents of intoxication resulting in medical and detox intervention related to becoming intoxicated and exhibiting unsafe behavior. The IJ was removed on 2/1/16, at 1:38 p.m. when the facility implemented interventions including assessing the residents safety, educating staff, implementing a safety contract with the resident, and ultimately discharging the resident from the facility. In addition, two complaint investigations were completed for H5438042, which was not substantiated, and for H5438043, which was substantiated with deficiencies cited at F311, F353, and F367. 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	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/26/2016

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.

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 _____	02/01/2016

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	Continued From page 1 your verification. An extended survey was conducted by the Minnesota Department of Health on 1/29/16 and 2/1/16.	F 000		
F 159 SS=E	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.	F 159		2/19/16

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 _____	02/01/2016

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 159	Continued From page 2 The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents had access to personal funds accounts after business hours, during evenings, and weekends for 2 of 2 residents (R8 and R25) who complained about restricted access to their account. This had the potential to affect 58 of 71 residents in the facility who had a personal account managed by the facility. Findings include: R8's quarterly Minimum Data Set (MDS) dated 11/2/15, identified R8 had no cognitive impairment. During interview on 1/25/16, at 3:48 p.m. R8 stated residents could not get money from their personal fund accounts on the weekends because there wasn't anyone at the front desk to access their account. R8 stated he wanted money from his account last weekend for the	F 159	Talahi Nursing and Rehab Center objects to and disagrees with both the findings of non-compliance and the level of deficiency cited.¿¿We do not believe that the conditions at Talahi Nursing and Rehab Center have caused actual harm or substandard quality of care. ¿ This Credible Allegation of Compliance has been prepared and timely submitted.¿¿Submission of this Credible Allegation of Compliance is not a legal admission that a deficiency exists or that the Statement of Deficiency were correctly cited, and is also not to be construed as an admission against interest of the Facility, its Administrator or any employees, agents or other individuals who draft or may be discussed in this Credible Allegation of Compliance.¿¿In addition, preparation and submission of this Credible Allegation of Compliance	

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 _____	02/01/2016

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 159	Continued From page 3 soda machine, but there was nobody at the front desk to access his account. R8 stated it upset him that he was not able to get his money when he wanted it. R25's quarterly MDS dated 11/9/15, identified R25 had no cognitive impairment. During interview on 1/28/16, at 9:38 a.m. R25 stated residents were unable to access their personal fund account on the weekends. R25 stated she had asked to get some money from her account two weeks ago on a Sunday, and the staff told her there were no staff at the facility who had access to get her money on the weekends. R25 stated, "That makes me so mad when I can't get my money when I want it." During interview on 1/27/16, at 1:06 p.m. business office manager (BOM) stated residents could get their money on Monday through Friday from 8:30 a.m. - 5:00 p.m., and Saturdays and Sundays between the hours of 8:30 a.m. - 3:30 p.m., and if residents came to the desk after hours to get money from their accounts, they would have to wait until the next morning to make a withdrawal. BOM stated staff do not have access to the residents' funds after hours, nor did the charge nurses have access to the resident funds. During interview on 1/28/16, at 9:45 a.m. director of nursing (DON) stated resident funds were located in the safe and residents, "Should always" have access to their personal funds from the charge nurse. During interview on 1/28/16, at 9:47 a.m. the administrator stated he had just became aware	F 159	does not constitute an admission or agreement of any kind by Facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. ¿ Accordingly, we are submitting this Credible Allegation of Compliance solely because state and federal law mandate submission of a Credible Allegation of Compliance within ten (10) days of receipt of the Statement of deficiencies as a condition to participate in the Medicare & Medical Assistance programs.¿¿The submission of the Credible Allegation of Compliance within this time frame should in no way be considered or construed as agreement with the allegations of non-compliance or admissions by the facility This plan and the individual responses are solely written to maintain certification in the Medicare and Medical Assistance programs. The written response does not constitute an admission of noncompliance with any requirement nor an agreement with any finding. We wish to preserve our right to dispute these findings in their entirety at any time and in any legal action. We may submit a separate request for Informal Dispute Resolution for certain findings and determinations F159 It is the Policy that all Talahi Nursing and Rehab Center Residents have access to	

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 _____	02/01/2016

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 159	Continued From page 4 this week that residents had concerns about being unable to access their personal funds accounts at all times, and stated residents should have access to their accounts 24/7 through the charge nurse. During interview on 1/28/16, at 10:03 a.m. registered nurse (RN)-A stated she did not have access to resident funds, and she had never seen the safe in the facility where the resident funds were kept. When interviewed on 1/28/16, at 10:15 a.m. licensed practical nurse (LPN)-A stated she worked as the charge nurse, and did not have access to the residents' funds, nor did she know where the safe is located to access the residents funds. The undated facility policy titled Resident Trust Account, indicated, "Residents may obtain or deposit funds at the front desk/reception area during the hours of 8:30 am-5:00 pm, Monday through Friday, and weekends and holidays 8:30 am-3:30 pm. After these hours residents may obtain funds from the charge nurse on duty."	F 159	their Resident Trust Funds at all times. The policy and procedure for The Management of Resident Funds was reviewed, updated and is current. Resident funds are now available to the residents outside of regular business hours. The change in the availability of Resident Trust Funds was communicated to Residents at the Resident Council Meeting held Feb 19, 2016. Education on policy and procedure to ensure Residents have access to their Resident Fund account was provided to staff responsible in the distribution of resident funds. Random Resident interviews will be completed weekly x 6 weeks. During random resident interviews, residents will be asked if they have requested access to their personal funds after business hours and if they received the requested funds. The facility alleges that it will be in substantial compliance and complete all action items by 02/19/16	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 221	F221	2/29/16

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 _____	02/01/2016

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 221	Continued From page 5 review, the facility failed to ensure physical restraints were comprehensively assessed to ensure the least restrictive device was used to treat the resident's medical symptoms for 1 of 1 resident (R39) reviewed who had a restraint. Findings include: R39's quarterly Minimum Data Set (MDS) dated 12/21/15, identified a diagnosis of dementia. R39 had severe cognitive impairment, required limited assistance from staff for transfers, and had a restraint in place on a daily basis. R39's Care Area Assessment (CAA) dated 7/3/15, identified "CAA triggered due to resident having a lap tray for fall prevention and for activities. Pt [patient] attempts to self transfer frequently through out the day. Had a lap buddy for some time but was able to remove it. Has a history of multiple falls. Patient is presently on hospice. Device is appropriate. No referrals." R39's care plan dated 1/6/16, identified risk for injury related to falls due to decreased strength and ambulation with an intervention "May use lap tray PRN [as needed]: restlessness, attempts to self transfer and to keep resident safe. On for 2H [two hours] and to removed for at least 15 minutes." Date initiated identified as 1/4/14, with a revision dated 5/27/14. R39's Restraint-Physical Evaluation dated 11/2/15, identified R39 required the restraint for unsteady gait, frequent falls, and attempts to self-transfer. Alternatives attempted included scheduled pain medication, anticipating hunger, pain, heat, cold, alarm devices - bed/chair/door, and medication review.	F 221	It is the policy that all Talahi Nursing and Rehab Center residents maintain the right to be free from any unnecessary physical restraints, will have comprehensive assessments completed to determine the least restrictive interventions to maintain safety and that if physical restraints are determined to be required they will be applied and managed per best practices, will be assessed on a regular basis and attempts at reduction will be implemented on a routine basis. Nursing Assistant Care Sheet was reviewed for accuracy regarding Restraint instructions for R39. Resident R 39 was re assessed for the use of the lap tray and referred to OT for evaluation. Lap Tray was discontinued. An evaluation was completed on R39 by OT for the use of the lap tray- currently in OT The care plan for R39 was reviewed and updated to reflect discontinue of lap tray and interventions implemented. Nursing assistant care sheet for R39 was updated to include discontinue of lap tray and new interventions. Resident information was assessed to identify all Residents in the building with active use of a restraint (no other current restraint use identified) The policy and procedure for the use of Restraints was reviewed and is current. Assessment and reduction attempt will be reviewed on a quarterly basis Education provided on the use of physical restraint devices in long term care, required	

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 _____	02/01/2016

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 221	Continued From page 6 R39's Safety Risk Data Collection dated 12/19/15, identified internal risk factors for falls included balance problems, pain, requiring assistance with toileting, impaired vision, decline in decision making skills, impulsiveness, dementia, and behaviors. External risk factors for falls included restraint use and physical devices. Physical devices were identified as half side rails, bed alarms tab, and a lap tray. R39's progress note dated 5/21/14, (over a year ago) indicated, "Spoke with [daughter] in regards to resident using the lap tray. Discussed benefits of her being able to place items on the tray for her to utilize or a place to put her drinks. Risks included decreased mobility, potential for increased incontinence, for resident to attempt to stand up and become entangled in the lap tray or try to get under the lap tray, and skin break down or bruising. She wishes to proceed with the utilization of the lap tray with an understanding of the benefits and the risks." R39's physician orders dated 1/26/16, did not identify R39 used a restraint or had a physician order to have a restraint in place. R39's progress note dated 5/9/14, identified "Received order for: OK for lap tray use for safety and positioning per family request. Lap tray to be removed and documented on every 2 hours for greater than 15 minutes. No seat belt while lap tray on and vice versa (no lap tray when seat belt alarm is on) OT [occupational therapy] must evaluate use before this can be started. OT will eval [evaluate] on 5/12/14 - Order on hold until then." The facility was unable to provide any documenting regarding an OT evaluation.	F 221	assessments/re-assessments/orders/consents, reduction attempts and documentation requirements. Release of restraint guidelines presented to direct care staff. 3 Random Audits will be completed on the use and release of physical devices weekly x 6 weeks. If restraints are in use audit will be observation of resident/staff, documentation, if no restraints currently in use, interview of floor staff will be utilized to determine understanding of compliance The facility alleges that it will be in substantial compliance and complete all action items by: 02/29/16	

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 _____	02/01/2016

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 221	Continued From page 7 On 1/26/16, at 12:43 p.m. R39 was observed in the dining room, with the lap tray in place on her wheelchair. Beverages were set on the dining table in front of her, however, the resident was not able to reach these because the lap tray was on. On 1/26/16, at 5:49 p.m. R39 was observed in the dining room, with the lap tray in place, and her water and juice were set on the dining table, which she was unable to reach because of the lap tray. At 6:28 p.m. nursing assistant (NA)-F placed a plate with food on the lap tray, however, the silverware remained on the dining table and R39 was unable to reach it. On 1/27/16, at 8:01 a.m. NA-F was observed assisting R39 with personal cares. NA-F placed R39 in her chair, and placed the lap tray. During continuous observation on 1/28/16, from 8:11 a.m. through 10:55 a.m. R39 was observed sitting in her wheelchair with the lap tray in place for the continuous observation. At 10:55 a.m. R39 was brought to her room and assisted to the bathroom at which time the lap tray was removed. When interviewed at this time, NA-B stated the lap tray was placed for two hours at a time, and then removed for 10-15 minutes, however, NA-B was not aware of the last time staff had removed R39's lap tray. During the continuous observation, R39 was not observed exhibiting any restlessness or behaviors. During interview on 1/25/16, 11:09 a.m. registered nurse (RN)-B stated R39 used a lap tray on top of the Broda chair (wheelchair) per family request, and stated she believed it was to be removed every two hours.	F 221		

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 _____	02/01/2016

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 221	Continued From page 8 During interview on 1/29/16, at 1:28 p.m. hospice aid (HA)-A stated R39 received the chair and lap tray through hospice services to promote independence, and it was only needed for eating and activities for the resident to have a tray to set things on. HA-A stated she had not observed R39 attempting to self-transfer. During interview on 1/29/16, at 2:19 p.m. hospice registered nurse (HRN) stated hospice had ordered the wheelchair and lap tray in May 2014, for stability, safety, restlessness, attempts at self-transfers, and for the resident to set things on the tray to promote independence. HRN stated the lap tray would not be considered a restraint as R39 had no recent falls or attempts at self-transferring, and the tray was to be used as needed, on for a maximum of two hours, and released for 15 minutes. HRN stated if R39 were attempting to get out of the wheelchair, staff were to encourage her to get up and ambulate, offer toileting, or anticipate needs before placing the lap tray on the wheelchair as a restraint. HRN stated the lap tray was not implemented to be in place at all times, and was meant to promote the resident independence only being utilized as needed. During a follow up interview on 2/1/16, at 8:19 a.m. RN-B stated there had been no attempt to reduce the amount of time the lap tray was used for R39 since initiation on 5/9/14, via the progress note. although the residents care plan indicated the lap tray was to be used as needed. During interview on 2/1/16, at 9:48 a.m. trained medication aid (TMA)-A stated R39 was physically capable of getting out of the wheelchair	F 221		

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 _____	02/01/2016

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 221	Continued From page 9 if the lap tray was not in place, and staff were directed to use it as needed, and remove it every two hours. However, TMA-A stated the lap tray was usually just kept on. During interview on 2/1/16, at 9:50 a.m. NA-B stated the lap tray was always on R39 when she was in the wheelchair, and she believed R39 attempted to stand when the lap tray was removed. The facility policy titled Safety review dated 9/15, indicated, "If a physical device is utilized, a physician's order for a physical device is required and must specify the type of device, specific reason (medical symptom) and duration of application." It also identified a resident utilizing a physical restraint is to be checked every 30 minutes by nursing staff, and the restraints are released and removed at least every two hours for 10-15 minutes for repositioning, range of motion and toileting.	F 221		
F 224 SS=G	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN 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 observation, interview, and document review, the facility neglected to comprehensively	F 224	F224 Rejection reason: were residents who	3/18/16

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 _____	02/01/2016

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 224	Continued From page 10 assess, develop interventions, and ensure safety measures were in place to protect 1 of 1 residents (R77) who was consuming alcohol and becoming intoxicated resulting in unsafe behavior. This resulted in actual harm to R77 who required multiple episodes of medical, police, and/or detox intervention as a result of consuming alcohol and becoming intoxicated, and although the facility was aware of R77's unsafe behavior, the facility neglected to ensure interventions were in place to prevent significant injury to R77 and/ or others. Findings include: R77's annual Minimum Data Set (MDS) dated 12/14/15, identified R77 had medical diagnosis' which included anxiety and manic depression, had no memory impairment and made, "Consistent/reasonable," decisions in daily tasks. The MDS identified R77 demonstrated no behaviors which put himself or others at risk for injury, and was independent with activities of daily living (ADLs). Although R77 was noted in the progress notes on 12/7/15, within the 7 day look back assessment period, to have left the facility and return intoxicated, the MDS assessment did not identify the resident had behaviors which put himself or others at risk for injury. R77's Admission Record dated 1/28/16, indicated an original admission date of 9/15/14, with a current admission date of 7/2/15. R77 had diagnoses including Alcohol Abuse with Unspecified alcohol-induced disorder, major depressive disorder, and anxiety disorder. During observation on 1/26/16, at 10:00 a.m. R77 walked up to the mobile medication cart outside the dining room and began to pace up and down	F 224	leave building unattended reassessed to ensure they were safe to do so Talahi Nursing and Rehab Center will utilize comprehensive assessments and the care planning process to implement interventions to maintain the safety of all Residents Resident R77 no longer resides at the facility All other residents who leave the building un attended were re □assessed for safety The process and procedure for residents to sign themselves out of the facility was reviewed and revised. Sign out/in binders have been created for each wing/unit and have been placed on each nurses station to increase the nurses awareness when residents are leaving and returning to the facility. The binders hold an individual sign out sheet for each resident. The facility admission packet was updated to include information on residents going off the unit, therapeutic LOA, independently Residents updated at Resident council meeting of new procedure to sign out for leaving the facility In collaboration with Social Services a process and procedure for identifying on admission, residents who wish to leave the facility independently will be developed. The policy and procedure for Resident Protection was reviewed and is current. All suspected vulnerable adult reports are reported to the appropriate state agency and Administrator/DON within the	

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 _____	02/01/2016

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 224	Continued From page 11 the hall while waiting for the nurse to visit with him. R77 then went outside and smoked a cigarette before coming back in to speak with the nurse, however, Licensed practical nurse (LPN)-B was still conversing with another resident, so R77 stood there tapping his hand on his cane for a few minutes until the nurse was able to visit with him. During observation of meal service on 1/28/16, at 4:41 p.m. R77's table setting was observed to have a paper plate and plastic cutlery sitting on the table. All of the other residents in the dining room were provided with metal utensils and ceramic dishes. When interviewed on 1/28/16, at 4:41 p.m., dietary aide (DA)-A stated he was unsure why R77 had paper and plastic cutlery. R77's Safety Risk Data Collection assessments dated 2/20/15, to 9/11/15, were reviewed and identified R77 had six Safety Risk Data Collection assessments completed during this time period. R77 had internal risk factors for falls which included hypertension, pain, impaired hearing and anxiety. R77 was identified as having a history of aggressive and abusive behaviors. The bottom of all six assessments contained a field to include a, "Summary of Data collected," however this portion of the assessment was blank. None of the six Safety Risk Data Collection assessments identified any information on R77's past or current alcohol use, including if he was safe to leave the facility, any signs or symptoms of withdrawal from alcohol, or potential aggression towards staff and/or residents resulted from consuming alcohol despite being identified upon admission has having a history of alcohol abuse. R77's Vulnerability Assessment dated 9/15/14,	F 224	regulatory and policy specific time frame. Resident Protection P&P, Vulnerable Adult reporting program referred to QA Education was provided to facility staff in regards to the vulnerable adult policy and procedure, along with reporting obligations and requirements of resident signing them out of the facility for LOA policy and procedure. DON or designee will complete daily audit of Progress notes and Risk Management/Incident report log to insure DON/Administrator or designee are being updated immediately of all incidents and potential VA reports and if not, individual corrective action is taken x 8 weeks. Audit of Vulnerable Adult for timely notification and complete investigation will be completed on all VA reports by IDT team at stand up. The facility alleges that it will be in substantial compliance and complete all action items by: 03/18/16	

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 _____	02/01/2016

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 224	Continued From page 12	F 224		

identified R77 had a vision impairment, and used a wheelchair for mobility. R77 had bipolar depression, and anxiety, but displayed no identified behaviors. R77's record lacked any further vulnerability assessments, and the assessment did not identify any information on R77's past or current alcohol use, including if he was safe to leave the facility, any potential risks for withdrawal from alcohol, or potential aggression towards staff and/or residents resulting from consuming alcohol despite being identified upon admission has having a history of alcohol abuse.

R77's Elopement Risk Assessment dated 9/18/15, identified R77 was, "Ambulatory or self-mobile in wheelchair," and had no identified concerns for poor decision making skills, or not being compliant with established facility protocols and policies regarding leaving the unit. The assessment did not identify any information on R77's past or current alcohol use, including if he was safe to leave the facility, any potential risks for withdrawal from alcohol, or potential aggression towards staff and/or residents resulted from consuming alcohol despite being identified upon admission has having a history of alcohol abuse.

R77's care plan dated 1/24/16, identified R77 had, "A behavior problem," and was, "Noted to consume alcohol and become intoxicated." The care plan identified a goal for R77 of, "Will have fewer episodes of being intoxicated by review date," and listed interventions for R77 including, "Intervene as necessary to protect the rights and safety of others," "When [sic] resident leaves facility upon return ask resident if he has alcohol in his possession," and, "Update MD as needed

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 _____	02/01/2016

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 224	Continued From page 13	F 224		

in regards to resident's continued alcohol consumption." The care plan did not identify what interventions staff should attempt if R77 was found to have alcohol in his room or on him, any behaviors R77 demonstrated while consuming alcohol, direction on how to handle any potential withdrawal symptoms for R77, or how to ensure he and others were kept safe if R77 was found to be consuming alcohol and intoxicated. R77's Care plan also directed staff to serve all meals on disposable dishes, "To prevent using dishes or utensils as a weapon."

R77's progress notes dated 1/6/15, to 1/28/16, identified the following entries in which R77 left the facility unsupervised and consumed alcohol, or required police, medical, or detox care as a result of consuming alcohol:

On 1/16/15, R77's roommate was found yelling for help. R77 was found in his room, "Face down next to [his] bed." R77 was unresponsive, and alcohol could be smelt on his breath. Staff located two empty bottles of alcohol in R77's drawers, and three knives were found in his pocket, after R77 had threatened staff earlier in the shift that day. Police and Ambulance services were called, and R77 remained unresponsive when they arrived. R77 was transferred to the hospital via ambulance at 10:30 p.m. On 1/17/15, at 4:00 a.m. the St. Cloud Hospital Emergency Department (ED) called the facility and stated R77's blood alcohol content was 0.22 and his unresponsiveness, "Was probably due to that." R77 returned to the facility at 6:55 a.m., alert and with his eyes open.

The corresponding hospital ED report was requested, but was not provided.

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 _____	02/01/2016

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 224	Continued From page 14 On 2/7/15, at 9:40 a.m. R77 was spoken to by facility staff after he was reported to have alcohol on him. R77 denied having any alcohol, nor anything to drink that day. R77 told staff, "I usually have some alcohol in the morning." R77's speech was slightly slurred during this interaction. At 11:43 a.m. facility staff contacted the St. Cloud Police Department as R77 was, "Noted to be verbally aggressive with staff." The facility staff removed one pint sized bottle of alcohol from his room, and it was locked in the medication room. On 3/7/15, at 2:00 p.m. R77 was found intoxicated on the floor in his room. R77 required an abdominal dressing change from staff, but he became angry and started to yell into the hallway, at one point ripping off his dressing and, "Showing other residents." R77 attempted to physically strike the nursing staff, and the police were notified. The police remained at the facility for a period of time, "To ensure [R77] would not harm anyone, and left without taking [R77] in." Later that day at 7:30 p.m., staff found R77 with a ½ full bottle of alcohol in his room. R77 became combative with staff, and the ambulance and police were notified. R77 continued to verbally threaten staff adding, "Just you wait until I come back, you are gonna get it." R77 was transferred to the ED after having to be restrained by three police officers. Staff searched R77's room and located two empty bottles of alcohol. On 3/8/15, R77 returned from St. Cloud Hospital ED and staff discussed his alcohol use and threatening behaviors with him. R77 agreed to not drink alcohol while in the facility, however, the facility had no corresponding assessment regarding how they would monitor R77's drinking, or develop interventions to ensure R77 abstained from	F 224		

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 _____	02/01/2016

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 224	Continued From page 15	F 224		

alcohol and was not a danger to himself or others.

R77's corresponding hospital record report, dated 3/7/15, identified R77 had been brought to the ED, "Because of intoxication and aggressive behavior." R77 admitted he had been drinking on that day, and when questioned about alcohol consumption during his medical review, R77 stated, "As much as possible." R77's blood alcohol level was, "Elevated at 0.3," and a final diagnosis of, "Alcohol intoxication, uncomplicated," was identified.

On 4/29/15, R77 was noted by staff as, "Being intoxicated during the day shift." R77 was still observed to be intoxicated and left the facility to go to the library at 3:00 p.m. that day and the progress notes indicated R77, "Was stumbling across parking lot and sidewalk as he walked to bus stop." R77 was returned to the facility by police later the same day at 6:30 p.m. The police had found R77, "Almost passed out in the library," and had noted he was drinking while at the library. In addition, the facility staff removed, "7 bottles of liquor from from [sic] room and locked them in med room. At least 4 were empty. They ranged in sizes from quart to pint to 8 oz [ounces] sizes." The staff removed these bottles from R77's room when he left the facility already intoxicated to go the library. Although staff noted R77 to be intoxicated on 4/29/15, the facility neglected to attempt to discourage the resident from leaving the facility, nor were any assessments completed to ensure R77 was safe.

On 6/25/15, R77 left the facility at 10:00 a.m. stating, "I am leaving for a while." R77 would not tell staff where he was going, "That's for me to

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 _____	02/01/2016

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 224	Continued From page 16	F 224		

know and you to not." On 6/26/15, at 1:36 p.m. (over 24 hours later) R77 still had not returned to the facility, nor made any contact with the staff regarding his whereabouts. At 3:52 p.m. the St. Cloud Police Department contacted the facility, and identified R77 had been arrested and transferred to Jail due to a warrant for his arrest. R77 would be released that day, and returned to the facility. The note identified, "[DON] and [administrator] updated on situation." R77's corresponding Incident/Arrest Report dated 6/25/15, identified R77 had been picked up by the police department, as was noted to have a razor, butter knife, and unopened bottle of brandy on him when arrested. R77 was found by police, "Laying next to war memorial" at Lake George, approximately 2 miles from the facility.

On 6/30/15, R77 became upset and accused staff of opening his magazines before he received them. R77 was swearing and, "Appears to be intoxicated." The nursing staff contacted the medical doctor (MD) and received orders to send him to the emergency room for his behaviors of threatening staff and other residents. An ambulance arrived to the facility at 11:10 a.m. and R77 began to yell at the ambulance crew that facility staff, "was stealing from him and that he does not need to go to the hospital." The police were notified and arrived at the facility. R77 continued, "Refusing to go [to] the ER for evaluation stating that he does not have to go and to call the paper as he is a member of ISIS to take care of things." R77 was removed from the facility by police at 11:50 a.m. At 3:40 p.m., facility staff documented R77 was, "Arrested and in jail at this time." R77 returned to the facility on 7/2/15, from St. Cloud Hospital.

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 _____	02/01/2016

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 224	Continued From page 17 R77's corresponding hospital record report, dated 6/30/15, identified R77 was brought to the ED via ambulance from the jail, "Because of the intoxication." R77 had been drinking alcohol and, "Has become belligerent, which subsequently led to a disorderly conduct charge." R77's breathalyzer was checked and 0.23 resulted, with Detox and the facility not accepting him due to being unable to ambulate steadily on his feet. On 8/1/15, R77 was identified as being out of the facility and was last seen in the morning at 8:30 a.m. At 1:45 p.m. the St. Cloud police department contacted the facility and stated R77 had been, "Brought to ED [emergency department] due to intoxication." The hospital nurse reported R77 was brought to the ED, "After falling at bus stop with inability to get back up and incoherence." R77 sustained abrasions to his knees and thighs, and had a blood alcohol content of 0.39, and would be sent to Detox if a bed was available. At 10:36 p.m. R77 was returned to the facility by a taxi cab due to no beds being available at Detox and, "Was still very intoxicated." R77 was unable to walk or stand on his own, and was assisted into the facility by staff at which time R77, "Saw another resident he began teasing him and hit him on the arm which upset the other resident." R77 also tried to convince that resident to come back to his room and continue drinking alcohol with him. R77's corresponding hospital report dated 8/1/15, identified R77 was, "Brought for evaluation with alcohol intoxication," after having falling at the bus station. R77 had left the nursing home and was drinking alcohol and was found, "With a bottle of brandy." The MD in the ED identified he was unable to obtain a complete	F 224		

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 _____	02/01/2016

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 224	Continued From page 18	F 224		

review of R77, "Until he was less intoxicated." A blood alcohol content was completed, and identified a 0.39 result. R77 was diagnosed with alcohol intoxication and a fall suffering a right knee abrasion, and discharged back to the facility with notes, "He will need to be observed closely."

On 11/3/15, R77 was documented as leaving the facility around 3:00 p.m. the day prior, on 11/2/15. At 7:00 a.m. on 11/3/15, R77 had not returned to the facility. At 1:57 p.m. the facility noted, "Informed res [resident] was at detox, did speak with resident, does not know when he will return."

R77's corresponding hospital report dated 11/3/15, identified R77 was brought to the ED via ambulance. R77 was, "Found outside of a bank in the bushes," and could not stand and was intoxicated. He was felt to be very cold, as the temperature outside, "Did get down into the lower 40s." R77 stated he was drinking, but was unable to recall when his last drink was prior to coming to the ED. The ED medical doctor (MD) identified a diagnosis of, "Alcohol intoxication with hypothermia," and listed R77's breathalyzer was 0.2 when performed. R77 was to be discharged to Detox when able to stand using his cane again. Although the facility was aware of R77's unsafe behavior when drinking and leaving the facility, there was no assessment completed or interventions put in place to ensure R77 was safe.

In addition to the above instances, R77's progress notes identified over 50 documented occurrences since 1/16/15, of R77 being found intoxicated; including eight times having to have his medications withheld, three times being found on the floor, nine times becoming verbally or

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 _____	02/01/2016

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 224	Continued From page 19	F 224		

physically aggressive with staff and/or residents, and six times having bottle(s) of full or consumed alcohol removed from his room. Despite the facility having knowledge of R77's unsafe behaviors, the facility neglected to ensure the resident was assessed and had interventions put into place to prevent harm to himself or other residents.

R77's Office Visit note completed by a physician on 10/22/15, identified R77 had a past medical history which included, "Alcoholism," and noted R77 had, "Multiple hx [history] of going through detox, multiple inpatient tx [treatment], and having withdrawal seizures and delirium tremors in the past." Although the facility was aware R77 had significant withdrawl symptoms in the past from alcohol, there was no assessment completed to ensure R77 was being monitored for signs or symptoms of alcohol withdrawl.

During interview on 1/27/16, at 2:14 p.m. nursing assistant (NA)-N stated R77 leaves the facility and comes back drunk and has an unsteady gait, and the smell of alcohol would be present when he returned. NA-N stated he was unaware of any interventions to prevent harm to R77 when he had been consuming alcohol, so staff just tell him to sleep, and stated, "Most of the time [he] just passes out." NA-N stated R77 was able to leave the building unsupervised and without any restrictions.

When interviewed on 1/27/16, at 2:22 p.m. NA-O stated R77 will drink alcohol at times, and had become angry and upset with staff, which is why the resident used plastic cutlery for meals; because of threatening staff with his utensils in the past. R77 frequently told staff he was going

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 _____	02/01/2016

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 224	Continued From page 20	F 224		

to the local library and then would return with alcohol. NA-O stated she was unaware of any interventions to prevent harm from occurring to R77 or other residents when he had been consuming alcohol, and stated, "Personally [I] am afraid of him."

When interviewed on 1/28/16, at 9:10 a.m. R77's county case worker (CW) stated she had been involved with R77 since September 2015, and was trying to help him find other housing services. CW had visited R77 multiple times and on different occasions noted him to be intoxicated to the point he was incoherent, and being unable to recognize she was even present at the facility with him. CW identified a pattern of R77 drinking towards the beginning of the month when he obtained his money from the government, and she had encouraged the facility to report R77 as a vulnerable adult related to his excessive alcohol use and unsafe behaviors.

During interview on 1/28/16, at 9:20 a.m. R77's medical doctor (MD)-K stated he was aware R77 was consuming alcohol and he had received several phone calls from the facility when R77 would be drinking alcohol, either at or away from the facility, at times having behaviors and, "Acting strange." MD-K stated R77 had been to his office for an appointment before while intoxicated, and stated R77 should not be consuming alcohol. MD-K stated R77 does not take appropriate care of himself, and it should be made so it was harder for R77 to be able to obtain and consume alcohol either at or away from the facility.

When interviewed on 1/28/16, at 10:00 a.m. registered nurse (RN)-B stated she was aware

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 _____	02/01/2016

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 224	Continued From page 21 R77 had left the facility and returned intoxicated, and stated R77 should not be consuming alcohol as it was, "Not good for him." R77's mood and behavior was different each time he consumed alcohol, and sometimes R77 would be happy and friendly, but other times he would become completely incoherent and disruptive to other residents. R77 had an order from his physician which identified he should not leave the building except for medical appointments, however, R77 would leave anyway, and added the facility had never completed an assessment to determine if R77 was safe to consume alcohol. RN-B stated staff were to ask R77 each time he returned to the facility if he had consumed alcohol, but RN-B was aware of no further interventions to prevent R77 from harming himself or others if he was found to be intoxicated. RN-B stated she was unsure of the exact date in which the last time R77 had consumed alcohol, however, thought it was sometime during the past two weeks. RN-B stated staff may not be documenting each time R77 was intoxicated as it had become, "The normal." During interview on 1/28/16, at 10:50 a.m. licensed social worker (LSW)-A stated R77 could potentially be a danger to himself, but was unaware if any assessment had been completed by the facility related to the unsafe behaviors R77 exhibited when intoxicated. During a follow up interview on 2/1/16, at 9:54 a.m. LSW-A stated she had been working closely with R77's case worker to discuss discharge options. LSW-A stated she was aware of R77's unsafe behaviors and his continued alcohol use, but stated, "He is his own person; he makes his own decisions." Although LSW-A was aware of R77's unsafe	F 224		

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 _____	02/01/2016

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 224	Continued From page 22 behaviors and ongoing excessive alcohol use, there were no interventions or social service involvement to ensure the resident and/ or other residents were safe, despite R77's past behaviors while intoxicated. When interviewed on 1/28/16, at 1:35 p.m. the director of nursing (DON) stated R77 had not been assessed for safety related to his unsafe behaviors while consuming alcohol. R77 had a physician order in place to not leave the facility as well as to not consume alcohol, however, it was discontinued on 1/8/16, because the resident was not following the order, and the facility would not stop him from drinking and/ or leaving the facility because he was his own person. Although the facility was aware of R77 unsafe behaviors while intoxicated, DON stated the facility had no assessment or interventions attempted to ensure R77 and/ or other residents were safe when the resident was intoxicated. Policies regarding the assessment of resident alcohol consumption were requested, but none were provided by the facility.	F 224		
F 225 SS=E	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 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	F 225		3/4/16

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 _____	02/01/2016

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 225	Continued From page 23 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 observation, interview, and document review, the facility failed to ensure allegations of mistreatment were were immediately reported to the administrator and the State agency for 5 of 6 residents (R50, R77, R76, R82, R70), and failed to ensure a complete investigation was submitted to the State agency for 1 of 6 residents (R77) whose allegations of mistreatment were reviewed.	F 225	F225 It is the policy of Talahi Nursing and Rehab Center that all potential VA incidents are managed to maintain regulatory compliance with notification of Administrator and DON and are submitted to the appropriate State Agencies in a timely manner, all incidents will have a	

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 _____	02/01/2016

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 225	Continued From page 24 Findings include: R50's quarterly Minimum Data Set (MDS) dated 10/17/15, indicated she was severely cognitively impaired and required extensive assistance with transfers and used a wheelchair. The MDS further indicated the resident had hallucinations and delusions and wandered one out of three days. R50's care plan dated 08/04/15, indicated, "The resident is at elopement risk r/t (related to) wandering behavior, impaired safety awareness, disorientation to place, and history of attempts to leave facility unattended." The facility Elopement Risk Assessment dated 8/3/15, indicated resident was ambulatory or self-mobile in wheelchair and was cognitively impaired with poor decision making-skills, and/or had a permanent diagnosis (e.g. dementia, OBS [organic brain disorder] , Alzheimer's, delusions, hallucinations, anxiety disorder, depression, manic depression, schizophrenia) and resident is alert but non-compliant with facility protocols regarding leaving the unit." The assessment was updated on 1/27/16, and indicated there was no changes in the elopement risk plan and, "Res [resident] continues to exit see at times. Will look out door window at times per activity staff." A VA (vulnerable adult) Investigative Packet dated 8/12/15, indicated on 8/12/15, at 1900 (7:00 p.m.), "Writer had been with resident just 10 minutes prior to the incident, sitting in her wheelchair, just outside of the dinning room. Resident wheeled herself outside of the facility doors and was found standing with her tabs alarm	F 225	complete and accurate investigation completed. Resident R77 no longer resides at the facility The occurrences for R50, R76, R70 and R82 were reviewed and Reported to OHF and investigations were initiated and/or continued. The policy and procedure for Vulnerable Adult reporting and investigation was reviewed and is current. All suspected vulnerable adult reports are reported to the DON and Administrator per policy guidelines All suspected vulnerable adult reports are reported to the appropriate state agency within the regulated time frame Resident Protection P&P, Vulnerable Adult reporting program referred to QA Education is provided to facility staff on the vulnerable adult policy and procedure, Investigation procedure and reporting obligations. DON or designee will complete daily review of Progress notes and Risk Management/Incident report log to insure DON/Administrator or designee are being updated immediately of all incidents and potential VA reports and if not, individual corrective action is taken x 8 weeks. Audit of Vulnerable Adult for timely notification and complete investigation will be completed on all VA reports by IDT team at stand up. The facility alleges that it will be in substantial compliance and complete all action items by: 03/04/16	

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 _____	02/01/2016

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 225	Continued From page 25	F 225		

in hand in the parking lot by fireside lounge at 1900. Resident was brought inside by a staff member who was not on duty. Resident is unable to verbalize what she was trying to do."

During interview 1/28/16, at 1:28 p.m. the DON stated" the Investigative Packet date was incorrect and should have been dated 8/2/15, the nurse was incorrect."

A Incident Submitted to MDH (Minnesota Department of Health)/ OHFC (office of health complaints) dated 08/03/15, indicated the incident occurred on 08/02/15, which was one day after the incident occurred. In addition, the report did not indicate when the administrator was notified.

During interview 1/28/16, at 2:00 p.m. the administrator stated he had only been at the facility for one month and was unaware if the previous administrator had been notified of the incident involving R50.

R76's quarterly MDS dated 1/21/16, indicated R76 had short and long term memory problems with disorganized thinking, and had severe impairment of cognitive skills for daily decision making.

R82's quarterly MDS, dated 11/6/15, identified R82 had moderate cognitive impairment with no behavioral concerns.

An incident report dated 11/1/15, indicated R76 entered R82's room at approximately 9:15 p.m. and punched R82 in the chest. The report indicated the administrator and the State agency were notified of the incident on 11/3/15, 2 days after the incident occurred. Also, the investigative

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 _____	02/01/2016

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 225	Continued From page 26	F 225		

report submitted on 11/10/15 to the State agency, incorrectly identified one of the residents involved.

During interview on 1/29/16, at 1:32 p.m., director of nursing (DON) reviewed the investigative report submitted to the State agency and verified one of the residents identified in the report was incorrect, and should have instead included R76 and R82. DON stated the incident was reported to her on 11/3/15, two days after it occurred. DON stated staff are directed to immediately report alleged mistreatment to the state agency and administrator.
R70's quarterly MDS dated 12/25/15, indicated R70 was cognitively intact, independent with locomotion on and off the unit, and demonstrated no wandering behaviors.

R70's Elopement Risk Assessment dated 9/17/15, identified R70 was at risk for elopement as he was a new admission to the facility, and displayed wandering behaviors at times. The assessment directed staff to care plan high risk for elopement, educate staff, re-evaluate all interventions at least quarterly, and notify staff and forward information and picture to the front desk.

Review of R70's nursing progress note dated 10/15/15, identified, "It was reported resident [R70] left facility at 2130 [9:30 p.m.] to walk to gas station and buy cigarettes. At 2225 [10:25 p.m.] writer received call from off duty CNA [certified nursing assistant] that she saw him walking along the street and stopped to talk to him. He asked directions to Talahi so she called facility and asked writer to meet her at the front door to help him in. He said he needed oxygen and couldn't walk any further, assisted to w/c [wheelchair] by

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 _____	02/01/2016

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 225	Continued From page 27	F 225		

front door and brought him to his room, O2 [oxygen] sat [saturation] checked on the way was 89, O2 started. He had a samber sticker on the top of one of his fingers and when asked if he fell he said 'no' that he had just laid down to rest on the way back."

During interview on 1/27/16, at 8:30 a.m. licensed social worker (LSW) stated she was not aware R70 eloped on 10/15/15, and the facility did not report the elopement to the state agency as, "It must have gotten missed."

When interviewed on 1/27/16, at 9:33 a.m. DON stated she was first notified of R70's 10/15/15, elopement this morning and stated staff should have reported this to the state agency and administrator.

R77's annual MDS dated 12/14/15, identified R77 had medical diagnosis' which included anxiety and manic depression, had no memory impairment, and made, "Consistent/reasonable," decisions in daily tasks. The MDS identified R77 demonstrated no behaviors which put himself or others at risk for injury, and was independent with activities of daily living (ADLs).

R77's progress note dated 5/6/15, indicated R77, "Had an altercation with another resident in the smoking room." R77 was identified to be, "Physically aggressive toward [another resident] resulting in injury," and R77, "Was noted to be intoxicated," when the incident occurred.

R77's Incident Report - Investigative Report (Office of Health Facility Complaints (OHFC) report dated 5/6/15, contained the submitted facility investigation from an incident which

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 _____	02/01/2016

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 225	Continued From page 28	F 225		

occurred on 5/6/15. The report identified an incident occurred between R77 and another resident in the facility. R77 was identified in the submitted investigation to have, "Grabbed the collar of [the other resident] shirt," and, "Punched him three times in the abdomen." The assaulted resident obtained bruising, scratches, and a skin tear as a result of being struck by R77. The St. Cloud police department was notified, and R77 was arrested, "With 5th degree assault charges," and taken into custody. R77 was released from police custody on 5/7/15, and returned to the facility with a plan which included having two staff present for all interactions with him, and R77 was not allowed to be in the smoking lounge any longer.

The investigative report submitted to the State agency (OHFC) did not contain all of the pertinent information regarding the incident, including identifying R77 was intoxicated when the incident took place.

Although the facility submitted an investigation to the State agency timely, the investigation was not complete and did not identify R77 had been consuming alcohol when the incident occurred, which could have influenced and/or caused the incident to occur.

R77's progress notes dated 10/12/15, through 10/16/15, identified another incident with R77 who had left the facility on 10/12/15, "With a friend," and had not returned. The facility contacted the St. Cloud police department, and indicated the facility, "Have no way of contacting him." R77 returned to the facility on 10/16/15, at 9:00 a.m. and told staff he had been, "Helping a sick friend." Facility staff identified they encouraged

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 _____	02/01/2016

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 225	Continued From page 29 R77 to call and keep in contact with the facility, however R77, "Laughed and stated 'Why would I do that?'" R77's Incident Report - Investigative Report (Office of Health Facility Complaints (OHFC) report dated 10/14/15, indicated the State agency (OHFC) had not been notified of R77's absence from the facility until two days after he was first identified by staff to be absent from the facility with his whereabouts unknown. During interview on 1/27/16, at 2:19 p.m. the director of nursing (DON) stated the facility nurses were submitting the reports to the state agency up until a month ago, however, corporate now made changes and the DON was now to make the reports. The DON if there is an allegation of mistreatment, reports should be immediately reported to the state agency and the administrator. The Facility's policy titled Resident Protection Policy and Procedure dated 7/1/15, included, "After safeguarding the resident as well as his/her rights, report the information to the Supervisor immediately...The supervisor in turn will immediately report all suspected maltreatment to the Administrator, DON, Social Service Director and to other officials in accordance with state law."	F 225		
F 226 SS=E	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	F 226		3/4/16

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 _____	02/01/2016

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 226	Continued From page 30 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 policies and procedures to include consistent, immediate reporting of allegations of mistreatment to the administrator and State agency for 5 of 6 residents (R50, R77, R76, R82, R70), whose allegations were reviewed. In addition, the facility failed to ensure a comprehensive investigation was submitted to the State agency for 1 of 6 residents (R77) with allegations of mistreatment. Findings include: The facility policy titled Resident Protection dated 7/1/15, identified an objective to, "Provide residents a safe environment that is free from harm," adding, "In accordance with Federal Regulation, the Resident Protection Plan establishes the policies and procedures for protecting the individuals that live at this facility." The policy identified a procedure for reporting potential or actual allegations of abuse and neglect which included, "The supervisor in turn will immediately report all suspected maltreatment to the Administrator, DON [director of nursing], Social Service Director and to other officials in accordance with state [sic] law." Further, the policy identified an internal investigation should be completed for all allegations of abuse or neglect and directed staff to submit an investigation report within 5 calendar days to the State agency including, "Details of [the] facility investigation."	F 226	F226 It is the policy of Talahi Nursing and Rehab Center that all potential VA incidents are managed to maintain regulatory compliance with notification of Administrator and DON and are submitted to the appropriate State Agencies in a timely manner, all incidents will have a complete and accurate investigation completed. Resident R77 no longer resides at the facility The occurrences for R50, R76, R70 and R82 were reviewed and Reported to OHF and investigations were initiated and/or continued and completed within the regulatory time frame. The policy and procedure for Vulnerable Adult reporting and investigation (Resident Protection P&P) is reviewed and is current. All suspected vulnerable adult reports are reported to the DON and Administrator per policy guidelines All suspected vulnerable adult reports are reported to the appropriate state agency within the regulated time frame Resident Protection P&P, Vulnerable Adult reporting program referred to QA Education is provided to facility staff on the vulnerable adult/Resident Protection	

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 _____	02/01/2016

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 226	Continued From page 31 R50's quarterly Minimum Data Set (MDS) dated 10/17/15, indicated she was severely cognitively impaired and required extensive assistance with transfers and used a wheelchair. The MDS further indicated the resident had hallucinations and delusions and wandered one out of three days. R50's care plan dated 08/04/15, indicated, "The resident is at elopement risk r/t (related to) wandering behavior, impaired safety awareness, disorientation to place, and history of attempts to leave facility unattended." R50's facility Elopement Risk Assessment dated 8/3/15, indicated resident was ambulatory or self-mobile in wheelchair and was cognitively impaired with poor decision making-skills, and/or had a permanent diagnosis (e.g. dementia, OBS [organic brain disorder] , Alzheimer's, delusions, hallucinations, anxiety disorder, depression, manic depression, schizophrenia) and resident is alert but non-compliant with facility protocols regarding leaving the unit." The assessment was updated on 1/27/16, and indicated there was no changes in the elopement risk plan and, "Res [resident] continues to exit see at times. Will look out door window at times per activity staff." A VA (vulnerable adult) Investigative Packet dated 8/12/15, indicated on 8/12/15, at 1900 (7:00 p.m.), "Writer had been with resident just 10 minutes prior to the incident, sitting in her wheelchair, just outside of the dinning room. Resident wheeled herself outside of the facility doors and was found standing with her tabs alarm in hand in the parking lot by fireside lounge at 1900. Resident was brought inside by a staff	F 226	policy and procedure, Investigation procedure and reporting obligations. DON or designee will complete daily review of Progress notes and Risk Management/Incident report log to insure DON/Administrator or designee are being updated immediately of all incidents and potential VA reports and if not, individual corrective action is taken x 8 weeks. Audit of Vulnerable Adult for timely notification and complete investigation will be completed on all VA reports by IDT team at stand up. The facility alleges that it will be in substantial compliance and complete all action items by: 03/04/16	

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 _____	02/01/2016

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 226	Continued From page 32	F 226		

member who was not on duty. Resident is unable to verbalize what she was trying to do."

During interview 1/28/16, at 1:28 p.m. the DON stated" the Investigative Packet date was incorrect and should have been dated 8/2/15, the nurse was incorrect."

A Incident Submitted to MDH (Minnesota Department of Health)/ OHFC (office of health complaints) dated 08/03/15, indicated the incident occurred on 08/02/15, which was one day after the incident occurred, and was not immediately reported according to the facility policy. In addition, the report did not indicate when the administrator was notified.

During interview 1/28/16, at 2:00 p.m. the administrator stated he had only been at the facility for one month and was unaware if the previous administrator had been notified of the incident as directed by the facility policy.

R76's quarterly MDS dated 1/21/16, indicated R76 had short and long term memory problems with disorganized thinking, and had severe impairment of cognitive skills for daily decision making.

R82's quarterly MDS, dated 11/6/15, identified R82 had moderate cognitive impairment with no behavioral concerns.

An incident report dated 11/1/15, indicated R76 entered R82's room at approximately 9:15 p.m. and punched R82 in the chest. The report indicated the administrator and the State agency were notified of the incident on 11/3/15, 2 days after the incident occurred. Also, the investigative

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 _____	02/01/2016

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 226	Continued From page 33	F 226		

report submitted on 11/10/15 to the State agency, incorrectly identified one of the residents involved.

During interview on 1/29/16, at 1:32 p.m., director of nursing (DON) reviewed the investigative report submitted to the State agency and verified one of the residents identified in the report was incorrect, and should have instead included R76 and R82. DON stated the incident was reported to her on 11/3/15, two days after it occurred. DON stated staff are directed by the facility policy to immediately report alleged mistreatment to the state agency and administrator.
R70's quarterly MDS dated 12/25/15, indicated R70 was cognitively intact, independent with locomotion on and off the unit, and demonstrated no wandering behaviors.

R70's Elopement Risk Assessment dated 9/17/15, identified R70 was at risk for elopement as he was a new admission to the facility, and displayed wandering behaviors at times. The assessment directed staff to care plan high risk for elopement, educate staff, re-evaluate all interventions at least quarterly, and notify staff and forward information and picture to the front desk.

Review of R70's nursing progress note dated 10/15/15, identified, "It was reported resident [R70] left facility at 2130 [9:30 p.m.] to walk to gas station and buy cigarettes. At 2225 [10:25 p.m.] writer received call from off duty CNA [certified nursing assistant] that she saw him walking along the street and stopped to talk to him. He asked directions to Talahi so she called facility and asked writer to meet her at the front door to help him in. He said he needed oxygen and couldn't walk any further, assisted to w/c [wheelchair] by

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 _____	02/01/2016

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 226	Continued From page 34	F 226		

front door and brought him to his room, O2 [oxygen] sat [saturation] checked on the way was 89, O2 started. He had a samber sticker on the top of one of his fingers and when asked if he fell he said 'no' that he had just laid down to rest on the way back."

During interview on 1/27/16, at 8:30 a.m. licensed social worker (LSW) stated she was not aware R70 eloped on 10/15/15, and the facility did not report the elopement to the state agency as, "It must have gotten missed."

When interviewed on 1/27/16, at 9:33 a.m. DON stated she was first notified of R70's 10/15/15, elopement this morning and stated staff should have reported this to the state agency and administrator according to the facility policy.

R77's annual MDS dated 12/14/15, identified R77 had medical diagnosis' which included anxiety and manic depression, had no memory impairment, and made, "Consistent/reasonable," decisions in daily tasks. The MDS identified R77 demonstrated no behaviors which put himself or others at risk for injury, and was independent with activities of daily living (ADLs).

R77's progress note dated 5/6/15, indicated R77, "Had an altercation with another resident in the smoking room." R77 was identified to be, "Physically aggressive toward [another resident] resulting in injury," and R77, "Was noted to be intoxicated," when the incident occurred.

R77's Incident Report - Investigative Report (Office of Health Facility Complaints (OHFC) report dated 5/6/15, contained the submitted facility investigation from an incident which

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 _____	02/01/2016

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 226	Continued From page 35	F 226		

occurred on 5/6/15. The report identified an incident occurred between R77 and another resident in the facility. R77 was identified in the submitted investigation to have, "Grabbed the collar of [the other resident] shirt," and, "Punched him three times in the abdomen." The assaulted resident obtained bruising, scratches, and a skin tear as a result of being struck by R77. The St. Cloud police department was notified, and R77 was arrested, "With 5th degree assault charges," and taken into custody. R77 was released from police custody on 5/7/15, and returned to the facility with a plan which included having two staff present for all interactions with him, and R77 was not allowed to be in the smoking lounge any longer.

The investigative report submitted to the State agency (OHFC) did not contain all of the pertinent information regarding the incident, including identifying R77 was intoxicated when the incident took place.

Although the facility submitted an investigation to the State agency timely, the investigation was not complete and did not identify R77 had been consuming alcohol when the incident occurred, which could have influenced and/or caused the incident to occur.

R77's progress notes dated 10/12/15, through 10/16/15, identified another incident with R77 who had left the facility on 10/12/15, "With a friend," and had not returned. The facility contacted the St. Cloud police department, and indicated the facility, "Have no way of contacting him." R77 returned to the facility on 10/16/15, at 9:00 a.m. and told staff he had been, "Helping a sick friend." Facility staff identified they encouraged

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 _____	02/01/2016

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 226	Continued From page 36 R77 to call and keep in contact with the facility, however R77, "Laughed and stated 'Why would I do that?'" R77's Incident Report - Investigative Report (Office of Health Facility Complaints (OHFC) report dated 10/14/15, indicated the State agency (OHFC) had not been notified of R77's absence from the facility until two days after he was first identified by staff to be absent from the facility with his whereabouts unknown, and not immediately as directed by the facility policy. During interview on 1/27/16, at 2:19 p.m. the director of nursing (DON) stated the facility nurses were submitting the reports to the state agency up until a month ago, however, corporate now made changes and the DON was now to make the reports. The DON if there is an allegation of mistreatment, reports should be immediately reported to the state agency and the administrator according to the facility policy.	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure soiled incontinence products were removed timely and not visible to other residents and visitors to ensure dignity for 1 of 1 residents (R23) observed	F 241	F241 It is the policy of Talahi Nursing and Rehab Center that residents will receive care in a manner and in an environment that maintains or enhances each	3/4/16

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 _____	02/01/2016

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 241	Continued From page 37 to have a soiled brief in the bedside trash basket. Findings include: R23's admission Minimum Data Set (MDS) dated 12/8/15, identified R23 had moderate cognitive impairment, and was frequently incontinent of urine. During observation on 1/26/16, at 12:57 p.m. R23's bedside trash basket in her room contained a visibly soiled, green colored incontinence product. The trash basket was sitting next to her bedside dresser, visible as you walked into her side of the room from the doorway. At 1:27 p.m. the soiled incontinent product remained in R23's bedside trash basket, in her room. When interviewed on 1/26/16, at 1:27 p.m. R23 stated staff have to help her change her incontinence products, and she wished they would take it with them as they leave the room. Family member (FM)-K was present during the interview, and stated she had observed incontinence products be left in R23's bedside trash before, and wished staff would remove them for R23. During a subsequent observation on 1/26/16, at 6:44 p.m. (nearly 6 hours later since first observed), R23's bedside trash continued to have the soiled incontinence product in it, visible to persons coming into her side of the room from the doorway. When interviewed on 1/27/16, at 1:09 p.m. nursing assistant (NA)-G stated staff change R23's incontinence product with morning cares, and place it in the trash, "Next to her bed." NA-G	F 241	resident□s dignity and respect in full recognition of his or her individuality. R23 - the garbage was removed upon notification. Education is provided to facility staff on the promotion of care in a manner that maintains or enhances the resident□s dignity and respect including the removal of soiled undergarments/incontinence products immediately after cares is completed. Policy and procedure for dignified care referred to QA. 5 Random weekly audits will be conducted on cares being provided in a dignified manner including the removal of incontinent undergarments x 6 weeks The facility alleges that it will be in substantial compliance and complete all action items by: 03/04/16	

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 _____	02/01/2016

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 241	Continued From page 38 stated the staff should be removing the soiled products immediately when finished, however, she has noticed soiled incontinence products being left in R23's room before, and let the charge nurse know about it. During interview on 1/28/16, at 8:58 a.m. registered nurse (RN)-A stated staff should remove the soiled incontinence products from R23's room, and leaving them sit in the bedside trash was a concern for, "Infection control and [the] resident's dignity."	F 241		
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 interview and document review, the facility failed to honor bathing preferences for 2 of 3 residents (R5 and R69) reviewed for bathing choices. Findings include: R5's admission Minimum Data Set (MDS) dated 9/27/15, indicated the resident was cognitively intact and required staff assistance with bathing. R5's care plan revised 1/27/16, indicated "The	F 242	F242 It is the policy of Talahi Nursing and Rehab Center that all residents have the right to choose activities, schedules and health care consistent with his or her interest, assessments and plans of care. R 5 and R 69 were interviewed for bathing preference. Activities will conduct a facility wide assessment of bathing preferences and present findings to IDT. All residents are interviewed upon	3/4/16

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 _____	02/01/2016

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 242	Continued From page 39 resident requires extensive assistance by 1 staff with bathing twice weekly." During interview 1/25/16, at 10:56 a.m. R5 stated she used to get three baths a week and now can only get two at the most. R5 stated she is supposed to get her baths on Monday and Friday's, and would like three baths a week. Review of the undated Bath Sign Out Sheet indicated R5 only received one bath the weeks of December 21st 2015, and the week of December 28th 2015. During interview on 1/27/16, at 7:20 a.m. nursing assistant (NA)-A stated she was the bath aide on the north wing and was aware R5 had missed her baths in the past, and some weeks she only received one bath a week. NA-A stated she was aware R5 would like three baths a week but due to lack of staffing she was unable to provide three baths a week as R5 requested. NA-A stated because of the lack of staffing she gets pulled to the floor to work as a nursing assistant so she had to prioritize, and tried to, "Get at least one bath a week for the residents." During interview on 1/27/16, at 7:40 a.m. registered nurse (RN)-A stated sometimes the bath aide gets pulled to the floor to assist with NA duties and they [the facility], "Guarantee the residents one bath a week and strive for two, they are unable to get three." R69's quarterly MDS dated 10/14/15, identified R69 had intact cognition and required staff assistance to complete bathing. During interview on 1/25/16, at 3:00 p.m. R69	F 242	admission/re-admission and preferences are reviewed at a minimum quarterly at care conference. Activities will give preferences to the care coordinator to discuss. Preferences will be communicated to Unit Coordinator, floor nursing and cna staff and communicated within the care plan and group sheets. Education completed on resident right to indicate and choose preferences, resident directed care and communication of resident preferences. Audits: Random Resident Audits will be completed on a weekly basis and will focus on their preference for bathing type and time of day. 5 audits per week x 6 weeks, then assessed with quarterly review. The facility alleges that it will be in substantial compliance and complete all action items by: 03/04/16	

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 _____	02/01/2016

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 242	Continued From page 40	F 242		

stated he did not always receive his desired two baths a week because the facility was short staffed.

R69's care plan dated 5/23/14, identified R69 required one staff to complete, "Bathing/showering twice weekly and as necessary."

An untitled facility bath list dated 1/23/16, identified R69 should receive a bath every Tuesday and Friday.

When interviewed on 1/27/16, at 7:05 a.m. NA-A stated she was the primary bath aide on R69's wing, made the bath list herself, and when a resident bath was completed she wrote it down on a notepad. NA-A stated R69 was scheduled for a twice weekly bath, but it wasn't consistently getting completed because the bath aide was being pulled to work on the floor to do NA duties due to lack of staffing. NA-A reviewed her documentation of resident baths completed and stated R69 had his last bath on 1/19/16, (8 days prior), and had not been consistently getting a twice weekly bath as he desired going back into December 2015.

During interview on 1/27/16, at 7:31 a.m. RN-A stated R69 should be getting a bath twice a week and staff, "Strive to give him two," however, it does not always get done because of the lack of staff. RN-A reviewed R69's bath logs provided by NA-A and stated the resident was not receiving his desired amount of baths and the facility would, "Definitely need to work on that."

A facility Bathing policy dated 12/2015, identified a purpose of developing a standardized method

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 _____	02/01/2016

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 242	Continued From page 41 for resident bathing. The policy identified staff should, "Provide tub bath or shower once a week," and added, "May provide more upon request."	F 242		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide medically related social services for 1 of 1 residents (R77) who became intoxicated and had behaviors which were a danger to himself and others. Findings include: R77's annual Minimum Data Set (MDS) dated 12/14/15, identified R77 had medical diagnosis' which included anxiety and manic depression, had no memory impairment, and made, "Consistent/reasonable," decisions in daily tasks. The MDS identified R77 demonstrated no behaviors which put himself or others at risk for injury, and was independent with activities of daily living (ADLs). R77's Admission Record dated 1/28/16, indicated an original admission date of 9/15/14, with a current admission date of 7/2/15. R77 had diagnoses including Alcohol Abuse with Unspecified alcohol-induced disorder, major depressive disorder, and anxiety disorder.	F 250	F250 It is the policy of Talahi Nursing and Rehab Center that all residents receive medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being. R 77 no longer resides at facility Audit of current Residents by Social Services for indicative triggers for risk of harm to self or others to be completed by Social Services Admission process and comprehensive assessment content reviewed and revised to include indicative triggers for risk of harm to self or others. Social services meets with all Residents a minimum of quarterly. Utilization of Daily IDT to ensure reviews of all resident changes are communicated successfully to Social Services. Assessment/evaluation and care planning process referred to QA.	3/9/16

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 _____	02/01/2016

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 250	Continued From page 42 During observation on 1/26/16, at 10:00 a.m. R77 walked up to the mobile medication cart outside the dining room and began to pace up and down the hall while waiting for the nurse to visit with him. R77 then went outside and smoked a cigarette before coming back in to speak with the nurse, however, Licensed practical nurse (LPN)-B was still conversing with another resident, so R77 stood there tapping his hand on his cane for a few minutes until the nurse was able to visit with him. During an observation of meal service on 1/28/16, at 4:41 p.m. R77's table setting was observed to have a paper plate and plastic cutlery sitting on the table. All of the other residents in the dining room were provided with metal utensils and ceramic dishes. When interviewed on 1/28/16, at 4:41 p.m., dietary aide (DA)-A stated he was unsure why R77 had paper and plastic cutlery. R77's Safety Risk Data Collection assessments dated 2/20/15, to 9/11/15, were reviewed and identified R77 had six Safety Risk Data Collection assessments completed during that time period. R77 had internal risk factors for falls which included hypertension, pain, impaired hearing and anxiety. R77 used half side rails on his bed secondary to his pain, and had good wheelchair positioning. R77 was identified as having a history of aggressive and abusive behaviors. The bottom of all six assessments contained a field to include a, "Summary of Data collected," however this portion of the assessment was blank, and not completed. R77's Vulnerability Assessment dated 9/15/14, identified R77 had a vision impairment, and used	F 250	Education provided to all staff regarding the roll of the Social Services/Social Worker and communication of Resident changes to involve Social services department. Education to all direct care staff regarding comprehensive admission/re-admission/incident assessment and care planning process in regards to potential self-harm/harm of other. Education to Social Services/Social Worker on effective comprehensive assessment process to ensure individualized care plan to ensure resident safety. Comprehensive assessment and care planning process to be reviewed by QA and random quarterly audits completed by QA. New admission □ QA to complete admission audit for indicative triggers and care planning of potential self-harm/harm to other issues with initial care conference x 15 admissions The facility alleges that it will be in substantial compliance and complete all action items by: 03/09/16	

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 _____	02/01/2016

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 250	Continued From page 43	F 250		

a wheelchair for mobility. R77 had bipolar depression, and anxiety, but displayed no identified behaviors. R77's record lacked any further vulnerability assessments upon review. The assessment did not identify any information on R77's past or current alcohol use.

R77's care plan dated 1/24/16, identified R77 had, "A behavior problem," and was, "Noted to consume alcohol and become intoxicated." The care plan identified a goal for R77, "Will have fewer episodes of being intoxicated by review date," and listed interventions for R77 including, "Intervene as necessary to protect the rights and safety of others," "when [sic] resident leaves facility upon return ask resident if he has alcohol in his possession," and, "Update MD as needed in regards to resident's continued alcohol consumption." The care plan did not identify any interventions staff should attempt if R77 was found to have alcohol in his room or on him, any behaviors R77 demonstrated while consuming alcohol, or how to ensure he and others were kept safe if R77 was found to be consuming alcohol. Further, the care plan directed staff to serve all meals on disposable dishes, "To prevent using dishes or utensils as a weapon."

R77's progress notes dated 1/6/15, to 1/28/16, identified the following entries in which R77 left the facility unsupervised and consumed alcohol, or required police, medical, or detox care as a result of consuming alcohol:

On 1/16/15, R77's roommate was found yelling for help. R77 was found in his room, "Face down next to [his] bed." R77 was unresponsive, and alcohol could be smelt on his breath. Staff located two empty bottles of alcohol in R77's

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 _____	02/01/2016

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 250	Continued From page 44	F 250		

drawers, and three knives were found in his pocket, after R77 had threatened staff earlier in the shift that day. Police and Ambulance services were called, and R77 remained unresponsive when they arrived. R77 was transferred to the hospital via ambulance at 10:30 p.m. On 1/17/15, at 4:00 a.m. the St. Cloud Hospital Emergency Department (ED) called the facility and stated R77's blood alcohol content was 0.22 and his unresponsiveness, "Was probably due to that." R77 returned to the facility at 6:55 a.m., alert and with his eyes open. There was no indication the social worker discussed the incident with R77, or assessed the resident to determine if the resident was safe and/ or needed further services for his alcohol use.

On 3/7/15, at 2:00 p.m. R77 was found intoxicated on the floor in his room. R77 required an abdominal dressing change from staff, but he became angry and started to yell into the hallway, at one point ripping off his dressing and, "Showing other residents." R77 attempted to physically strike the nursing staff, and the police were notified. The police remained at the facility for a period of time, "To ensure [R77] would not harm anyone, and left without taking [R77] in." Later that day at 7:30 p.m., staff found R77 with a ½ full bottle of alcohol in his room. R77 became combative with staff, and the ambulance and police were notified. R77 continued to verbally threaten staff adding, "Just you wait until I come back, you are gonna get it." R77 was transferred to the ED after having to be restrained by three police officers. Staff searched R77's room and located two empty bottles of alcohol. On 3/8/15, R77 returned from St. Cloud Hospital ED and staff discussed his alcohol use and threatening behaviors with him. R77 agreed to not drink

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 _____	02/01/2016

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 250	Continued From page 45	F 250		

alcohol while in the facility. There was no indication the social worker discussed the incident with R77, or assessed the resident to determine if the resident was safe and/ or needed further services for his alcohol use.

R77's corresponding hospital record report, dated 3/7/15, identified R77 had been brought to the ED, "Because of intoxication and aggressive behavior." R77 admitted he had been drinking on that day, and when questioned about alcohol consumption during his medical review, R77 stated, "As much as possible." R77's blood alcohol level was, "Elevated at 0.3," and a final diagnosis of, "Alcohol intoxication, uncomplicated," was identified.

On 5/6/15, R77 had an altercation with a resident in the smoking room in which he was physically aggressive and resulted in an injury. R77 was noted to be intoxicated. A progress note by licensed social worker (LSW)-A after the altercation, indicated the Medical Director (MD) was notified regarding the altercation and he advised staff to contact R77's oncologist to inform them of R77's choice to consume alcohol while taking chemotherapy medications, to inquire as to whether that was an imminent threat to his health, and the possibility of needing to pursue a 72 hour hold. MD also advised facility staff to contact the primary physician for the possibility of starting commitment proceedings for Adult Mental Health.

On 6/25/15, R77 left the facility at 10:00 a.m. stating, "I am leaving for a while." R77 would not tell staff where he was going, "That's for me to know and you to not." On 6/26/15, at 1:36 p.m. (over 24 hours later) R77 still had not returned to the facility, nor made any contact with the staff

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 _____	02/01/2016

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 250	Continued From page 46	F 250		

regarding his whereabouts. At 3:52 p.m. the Police Department contacted the facility, and identified R77 had been arrested and transferred to Jail due to a warrant for his arrest. R77 would be released that day, and returned to the facility. The note identified, "[DON] and [administrator] updated on situation." R77's corresponding Incident/Arrest Report dated 6/25/15, identified R77 had been picked up by the police department, as was noted to have a razor, butter knife, and unopened bottle of brandy on him when arrested. R77 was found by police, "Laying next to war memorial" at Lake George, approximately 2 miles from the facility. There was no indication the social worker discussed the incident with R77, or assessed the resident to determine if the resident was safe and/ or needed further services for his alcohol use.

On 8/1/15, R77 was identified as being out of the facility, being last seen in the morning at 8:30 a.m. At 1:45 p.m. the St. Cloud police department contacted the facility and reported R77 had been, "Brought to ED [emergency department] due to intoxication." The hospital nurse reported R77 was brought to the ED, "After falling at bus stop with inability to get back up and incoherence." R77 sustained abrasions to his knees and thighs, and had a blood alcohol content of 0.39, and would be sent to Detox if a bed was available. At 10:36 p.m. R77 was returned to the facility via taxi cab due to no beds being available at Detox and, "Was still very intoxicated." R77 was unable to walk or stand on his own, and was assisted into the facility by staff at which time R77, "Saw another resident he began teasing him and hit him on the arm which upset the other resident." Further, R77 tried to convince that resident to come back to his room and continue drinking with

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 _____	02/01/2016

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 250	Continued From page 47	F 250		

him. There was no indication the social worker discussed the incident with R77, or assessed the resident to determine if the resident was safe and/ or needed further services for his alcohol use.

R77's corresponding hospital report dated 8/1/15, identified R77 was, "Brought for evaluation with alcohol intoxication," after having fallen at the bus station. R77 had left the nursing home and was drinking alcohol, being found, "With a bottle of brandy." The MD in the ED identified he was unable to obtain a complete review of R77, "Until he was less intoxicated." A blood alcohol content was completed, and identified a 0.39 result. R77 was diagnosed with alcohol intoxication and a fall suffering a right knee abrasion, and discharged back to the facility with notes, "He will need to be observed closely."

On 11/3/15, R77 was documented as having left the facility around 3:00 p.m. the day prior, on 11/2/15. At 7:00 a.m. on 11/3/15, R77 had not returned to the facility. At 1:57 p.m. the facility noted, "Informed res [resident] was at detox, did speak with resident, does not know when he will return."

R77's corresponding hospital report dated 11/3/15, identified R77 was brought to the ED via ambulance. R77 was, "Found outside of a bank in the bushes," and could not stand and was intoxicated. He was felt to be very cold, as the temperature outside, "Did get down into the lower 40s." R77 stated he was drinking, but was unable to recall when his last drink was prior to coming to the ED. The ED medical doctor (MD) identified a diagnosis of, "Alcohol intoxication with hypothermia," and listed R77's breathalyzer was

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 _____	02/01/2016

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 250	Continued From page 48	F 250		

0.2 when performed. R77 was to be discharged to Detox when able to stand using his cane again. There was no indication the social worker discussed the incident with R77, or assessed the resident to determine if the resident was safe and/ or needed further services for his alcohol use.

In addition to the above instances, R77's progress notes identified over 50 documented occurrences since 1/16/15, of R77 being found intoxicated, including eight times having to have his medications withheld, three times being found on the floor, nine times becoming verbally or physically aggressive with staff and/or residents, and six times having bottle(s) of full or consumed alcohol removed from his room.

Further, a listing of previous ED visits for R77 dated 11/3/15, identified R77 had been to the ED thirteen times since 8/3/13 for alcohol abuse and/or intoxication.

R77's Office Visit note, completed by a physician on 10/22/15, identified R77 had a past medical history which included, "Alcoholism," and noted R77 had, "Multiple hx [history] of going through detox, multiple inpatient tx [treatment], and having withdrawal seizures and delirium tremens in the past."

When interviewed on 1/28/16, at 9:10 a.m. R77's county case worker (CW) stated she had been involved with R77 since September 2015, and was trying to help him find other housing services. CW had visited R77 multiple times and on different occasions noted him to be intoxicated to the point he was incoherent, and being unable to recognize she was even present at the facility

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 _____	02/01/2016

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 250	Continued From page 49	F 250		

with him. CW had identified a pattern of R77 drinking towards the beginning of the month, as that was when he obtained his money from the government, and encouraged the facility to report R77 as a vulnerable adult because R77 did not feel he had an alcohol problem.

During interview on 1/28/16, at 10:50 a.m. LSW-A stated R77 could potentially be a danger to himself and she had not completed any assessment, or implemented any interventions to determine if the resident required any further services, and to determine if the resident and /or other residents were safe while R77 was intoxicated.

During a follow up interview on 2/1/16, at 9:54 a.m. LSW-A stated she had been working closely with R77's case worker to discuss discharge options. LSW-A stated she was aware of R77's unsafe behaviors and his continued alcohol use, but stated, "He is his own person; he makes his own decisions." LSW-A stated she tried to find ways that they could stop R77's drinking, however, R77 didn't feel he had a problem with alcohol, so nothing was pursued. LSW-A stated she had spoken to R77's physician previously [about 6-7 months prior] about proceeding with possible commitment or 72 hold, however, she had not followed up to determine if this was an option.

Although the LSW was aware of R77's ongoing consumption of alcohol and unsafe behaviors while intoxicated, there was no indication the social worker discussed with R77 his alcohol use,

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 _____	02/01/2016

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 250	Continued From page 50 offered further services to R77 regarding his alcohol use, or assessed the resident to determine if the resident was safe in the facility.	F 250		
F 257 SS=D	483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure comfortable room temperatures were maintained for 1 of 4 residents (R69) who complained about their room temperature. Findings include: R69's quarterly Minimum Data Set (MDS) dated 10/14/15, identified R69 had intact cognition. During observation on 1/25/16, at 3:01 p.m. R69 was seated in his room. R69 had a small white fan running which was placed on his electric chair, and stated the temperature of his room was too warm so he needed to use the fan to cool it down. When interviewed on 1/29/16, at 9:27 a.m. nursing assistant (NA)-A stated R69 had complained about his room being too warm and only sleeps with a light sheet and thin blanket during the night. NA-A stated R69 usually had a small white fan running because of the heat in his	F 257	F257 It is the policy of Talahi Nursing and Rehab Center that they will provide a safe and comfortable environment for all Residents R69 was interviewed and the room temperature for R69 was adjusted to meet the resident□s preferences Temperatures in rooms and common areas are tested and in regulatory compliance. Education was completed with staff in regards to resident preferences in room temperatures along with reporting to the Engineering department when the temperature is not meeting the resident□s preferences. Interviews of random residents will be conducted weekly to assure room temperature is meeting the resident□s preferences. 5 interviews per week x 6 weeks Policy and Procedure to maintain a	3/1/16

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 _____	02/01/2016

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 257	Continued From page 51 room. NA-A stated she had reported R69's warm room temperature to the previous maintenance director, however, she was unsure if the current maintenance director was aware of R69's ongoing concern of the warm room temperature. NA-A stated staff should be filling out maintenance slips when they note problems with resident rooms to ensure they are fixed. During interview on 1/29/16, at 10:35 a.m. the maintenance director stated he had never received any notification R69 was too warm in his room, and if staff had noticed concerns they should have notified maintenance to have it addressed. A facility policy on room temperature adjustment was requested, but none was provided.	F 257	comfortable environment referred to QA Ongoing audits consisting of Interviews of random residents will then be conducted quarterly. The facility alleges that it will be in substantial compliance and complete all action items by: 03/01/16	
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	F 279		3/4/16

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 _____	02/01/2016

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 52 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 interventions for elopement for 1 of 1 residents (R70) reviewed for wandering and who was identified at risk for elopement. Findings include: R70's admission Minimum Data Set (MDS) dated 9/24/15, indicated R70 had a diagnoses of bipolar disease and respiratory failure, had short term memory problems, was inattentive, and displayed disorganized thinking. R70 was independent with locomotion on and off the unit, and exhibited wandering behaviors which placed R70 at significant risk of getting to potential dangerous places. R70's care area assessments (CAA) for cognition loss/dementia, falls, and behavior dated 10/1/15, identified R70 required assistance with making safe decisions in regards to exiting the facility unattended and non-compliance with wearing his oxygen. R70 had displayed wandering behaviors and had eloped from the facility on the first day after admission. These CAA's identified staff would address these identified concerns, "In the care plan." R70's care plan dated 1/11/16, identified R70 was at a high risk for falls related to psychoactive drug use and gait/balance problems; however, the	F 279	F279 It is the policy that Talahi Nursing and Rehab Center will develop a comprehensive care plan that will meet the resident□s medical, nursing and mental and psychosocial needs. R70 Care plan, assessments were reviewed and updated to accurately reflect needs to maintain safety Facility wide audit of all residents for elopement risk and appropriate care plan development Review of elopement policy & Procedure was completed and is current. Elopement risk assessment and care plan review will be completed a minimum of quarterly. Assessment/evaluation and care planning process referred to QA. All staff provided education on Elopement policy and Procedure Monthly Audit of assessments and care plans for At Risk for Elopement Residents to be presented and reviewed at QA	

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 _____	02/01/2016

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 53 care plan did not identify R70 was an elopement risk, nor were there any interventions to prevent R70 from elopement. When interviewed on 1/27/16, at 9:25 a.m. registered nurse (RN)-B stated when R70 left the building he usually walked to the gas station that was about four to five blocks from the nursing home. She also stated R70 would never sign out to let staff know when he left the building. RN-B stated the facility had no care plan interventions regarding elopement for R70. A facility policy titled Careplan dated 6/2015, indicated all residents would have a plan of care which accurately reflected the residents' needs and strengths to guide staff in providing care. The procedure included the comprehensive MDS assessment needed to be completed within seven days of admission, and the assessment would be used to complete the CAA's for the resident by day 14 of their stay, and the CAA's would be used to complete a comprehensive care plan for the resident by day 21.	F 279	The facility alleges that it will be in substantial compliance and complete all action items by: 03/04/16	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the plan of care was implemented as directed for timely	F 282	F282 It is the policy of Talahi Nursing and	2/29/16

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 _____	02/01/2016

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 282	Continued From page 54 dressing removal for 1 of 1 resident (R53) reviewed for dialysis. In addition, the facility failed to ensure the plan of care was implemented for timely release of a restraint, timely toileting, assistance with eating, oral care, and shaving for 1 of 3 residents, (R39) reviewed for activities of daily living. Findings include: R53's quarterly Minimum Data Set (MDS) dated 12/17/15, identified diagnosis including dementia and end stage renal disease, and indicated R53 had severe cognitive impairment. R53's care plan dated 12/30/15, indicated the resident received hemodialysis related to renal failure and staff was instructed to complete dialysis communication form before and after dialysis run, and fax to KDU if they have not completed their part, monitor access site daily for signs and symptoms of infection, and the nurse was to remove the dialysis dressing from the residents right arm dialysis access four hours post dialysis run. On 1/27/16, at 6:53 a.m. R53 was observed lying down on the couch in the commons area. R53 had received dialysis the day prior on 1/26/16, however, the dressing remained on her right arm dialysis site from treatment the day prior. When interviewed on 1/27/16, at 7:52 a.m. registered nurse (RN)-B stated the dressing on R53's right arm was placed at dialysis the previous day, and it should have been removed the prior evening according to the residents care plan.	F 282	Rehab Center that there is collaboration between providers to ensure the highest level of care is achieved for all Residents. The care plan for resident R 39 was reviewed for activities of daily living, toileting needs, repositioning and restraint removal. R 53 care plan was reviewed for post dialysis care and oral cares and is current and accurate. All care plans are reviewed in conjunction of the RAI process. The policy for care plans and the care planning process has been reviewed and is current. Education: Education was competed for direct care staff on following the plan of care Audits: Weekly audits of care provided per the developed plan of care will be conducted on 5 random residents x 6 weeks. The facility alleges that it will be in substantial compliance and complete all action items by: 02/29/16	

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 _____	02/01/2016

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 282	Continued From page 55 The facility policy titled Dialysis Program Guidelines dated 1/11/11, identified dialysis dressing is to be removed four hours after discharge from dialysis. Staff are also to use the care plan which is developed as collaboration. R39's quarterly MDS dated 12/21/15, identified a diagnosis of dementia, indicated the resident had severe cognitive impairment, required limited assistance from staff for transfers, required staff assistance for eating, toileting, and grooming, was always incontinent of bowel, and had a restraint used on a daily basis. R39's care plan dated 1/6/16, identified risk for injury related to falls due to decreased strength and ambulation, with an intervention "May use lap tray PRN [as needed]: restlessness, attempts to self transfer and to keep resident safe. On for 2H [two hours] and to removed for at least 15 minutes." The care plan also directed staff R39 required staff assistance with eating, toileting, grooming, transfers, and bed mobility; and R39 was at risk for pressure ulcers and was to be turned, repositioned, or offloaded every two hours for at least one minute and as needed. Restraint- During continuous observation on 1/28/16, from 8:11 a.m. through 10:55 a.m. R39 was observed with the lap tray in place on her wheelchair. At 10:53 a.m. R39 was brought to her room, and at 10:55 a.m. the tray was removed, and R39 was assisted to the bathroom. When interviewed at this time, nursing assistant (NA)-B stated the tray was placed for two hours and removed for 10-15 minutes, however, NA-B was not aware the last time R39's lap tray had been removed.	F 282		

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 _____	02/01/2016

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 282	Continued From page 56	F 282		

When interviewed on 1/29/16, at 1:28 p.m. hospice aid (HA)-A stated R39 received the chair and lap tray through hospice to promote independence, and it would only be needed for eating and activities, and was not required to be kept on at all times.

When interviewed on 1/29/16, at 2:19 p.m. hospice registered nurse (HRN) stated hospice ordered the chair and lap tray for stability, safety, restlessness, and attempts at self-transfers. HRN stated the tray was implemented to increase R39's independence so things could be set on the tray, and was implemented in May 2014. HRN stated the lap tray should be used as needed, on for a maximum of two hours, and released for 15 minutes.

When interviewed on 2/1/16, at 8:19 a.m. RN-B stated there had been no attempt in a reduction for the amount of time the lap tray was used on R39 since initiation, and the care plan indicated the lap tray was to be used as needed, and to ensure it was released every two hours.

When interviewed on 2/1/16, at 9:48 a.m. trained medication aid (TMA)-A stated R39 was only to use the lap tray as needed, and the care plan instructed staff to remove the lap tray every two hours.

When interviewed on 2/1/16, at 9:50 a.m. NA-B stated R39's lap tray was always kept on when she was up in the wheelchair, and it was to be released every two hours.

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 _____	02/01/2016

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 282	Continued From page 57 Eating During observation on 1/28/16, at 8:29 a.m. R39 was brought to the dining room, and pushed up to the table, with the lap tray between resident and the table. At 8:52 a.m., food was provided and set on the dining room table out of the reach of R39. At 8:54 a.m. NA-C placed a bowl of oatmeal on the tray and encouraged R39 to eat, and also provided R39 a glass of chocolate milk, which she drank independently, and began to pour it into her oatmeal. NA-C stated "oh, what did you do", and continued to assist R39's tablemate with eating. R39 remained at the table, with the biscuit, eggs, and gravy, along with beverages out of reach on the table. At 9:08 a.m. NA-B placed the clothing protector on R39, cleaned up the tray, and placed the plate on her tray, and left the area; R39 made no attempts to feed herself. At 9:12 a.m. NA-D sat and assisted R39 to eat a couple bites, and then got up and left the dining room; after NA-D left, R39 made no attempts to feed herself. At 9:29 a.m. NA-D returned and assisted R39 to eat before removing her from the dining room at 9:35 a.m. When R39 was provided assistance, she ate about 75% of her meal, and drank all of the beverages. When interviewed on 1/26/16, at 2:43 p.m. family member (FM)-L stated when she comes to visit during supper time R39 was often sitting at the dining room table and there are no staff assisting her with eating. When interviewed on 1/28/16, at 11:53 a.m. NA-B stated R39 was at times able to eat independently, however, she will often just take a few bites and then stop, which is when staff should be assisting her to eat. NA-B stated staff were to be sitting at the table with R39 throughout	F 282		

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 _____	02/01/2016

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 282	Continued From page 58	F 282		

the meal, and this morning when she entered the dining room there were no staff assisting R39.

When interviewed on 2/1/16, at 8:11 a.m. RN-B stated R39's care plan indicated she was to have one staff assisting during meals, and staff was expected to follow the care plan.

Toileting
During continuous observation on 1/28/16, from 8:11 a.m. through 10:55 a.m. (two hours and 44 minutes) R39 was observed sitting in her chair in the hallway, was brought to the dining room for breakfast, returned to the hallway, and then was taken to an activity. During the continuous observation R39 was not offered toileting and staff did not check her incontinent pad. At 10:55 a.m. R39 was brought to her room and offered toileting, and her incontinent pad had a large amount of stool present in the incontinent pad.

When interviewed at this time, NA-E stated she was not aware of the last time R39 was toileted or had her incontinent pad changed, and stated R39 was to be toileted every two hours.

During interview on 1/28/16, at 11:42 a.m. NA-C stated R39 was typically incontinent when toileted.

When interviewed on 2/1/16, at 8:29 a.m. RN-B stated R39 was to be offered toileting every two hours and as needed per the care plan, and it would not be acceptable for R39 to go two hours and 44 minutes without being offered toileting.

Shaving/ oral hygiene
During observation on 1/25/16, at 10:53 a.m. R39

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 _____	02/01/2016

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 282	Continued From page 59 was observed with multiple facial hairs on her chin. During observation on 1/26/16 at 6:41 p.m. R39 observed in the dining room and still had multiple facial hairs visible on her chin. During observation on 1/27/16, at 8:01 a.m. NA-F performed morning personal cares on R37. NA-F assisted R37 to put the dentures in her mouth, however, there was no oral hygiene completed using a toothette according to the care plan, and no shaving was offered. When interviewed on 1/26/16, at 2:43 p.m. FM-L stated staff should be shaving R39's facial hair, and she does not like seeing them. When interviewed on 2/1/16, at 8:29 a.m. RN-B stated staff are to follow R39's plan of care when providing assistance with activities of daily living, which include oral care and shaving. Facility policy titled ADL [Activities of Daily Living] Policy review date 10/13, identified all staff will follow care plans and provide assistance with ADL's. Facility policy titled Care Plan revision date 6/15, did not address following the care plan.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in	F 309		2/29/16

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 _____	02/01/2016

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 309	Continued From page 60 accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure coordination of care with an outside dialysis provider for 1 of 1 resident (R53) reviewed for dialysis. In addition, the facility failed to comprehensively assess and develop interventions for 1 of 1 resident (R76) who exhibited behaviors with bathing. Findings include: R53's quarterly Minimum Data Set (MDS) dated 12/17/15, identified diagnosis including dementia and end stage renal disease, and indicated R53 had severe cognitive impairment. R53's Physician orders dated 3/26/15, identified: - check fistula for bruit/thrill right arm every shift. - complete dialysis assessment upon return from KDU [kidney dialysis unit] and update as needed. - remove dressing to dialysis site four hours after dialysis run. R53's care plan dated 12/30/15, indicated the resident received hemodialysis related to renal failure and staff was instructed to complete dialysis communication form before and after dialysis run, and fax to KDU if they have not completed their part, monitor access site daily for signs and symptoms of infection, and the nurse was to remove the dialysis dressing from the residents right arm dialysis access four hours post dialysis run.	F 309	F309 It is the policy of Talahi Nursing and Rehab Center that all direct care staff are providing cares per plan of care. Staff RN completed dressing change and initiated monitoring of site. Investigation completed of whether treatment was signed without treatment given In response to above stated investigation - Staff LPN & TMA were educated and disciplined as appropriate regarding scope of practice, documentation guidelines, completion of treatments as ordered and communication of task needs R 53 care plan was reviewed and revised to include collaboration between the dialysis provider and facility. R 76 care plan was reviewed and revised to include interventions to promote bathing Education provided to clinical staff in regards to collaboration between dialysis providers and to provide care to residents that suffer from cognitive impairment and refusal of cares. Education of direct care staff regarding scope of practice, documentation guidelines and communication of task needs Audits will be completed on collaboration	

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 _____	02/01/2016

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 309	Continued From page 61 R53's Medication Administration Record (MAR) / Treatment Administration Record (TAR) for January 2016, instructed nursing to remove the dressing to the dialysis site four hours after the dialysis run. The entry for 1/26/16, was signed off as being completed. On 1/27/16, at 6:53 a.m. R53 was observed lying down on the couch in the commons area. R53 had received dialysis the day prior on 1/26/16, however, the dressing remained on her right arm dialysis site from treatment the day prior. When interviewed on 1/27/16, at 7:52 a.m. registered nurse (RN)-B stated the dressing on R53's right arm was placed at dialysis the previous day, and it should have been removed the prior evening, as staff was instructed to ensure the dialysis dressing was removed four hours after returning from dialysis. RN-B was unsure why R53's MAR was signed off indicating the dressing on the dialysis site was removed. The facility policy titled Dialysis Program Guidelines dated 1/11/11, identified dialysis dressing is to be removed four hours after discharge from dialysis. Staff are also to use the care plan which is developed as collaboration. The Agreement to Provide Dialysis Services, signed by the facility and outside dialysis facility dated 9/11/12, identified the dialysis provider and skilled nursing facility together shall develop a plan of care for each dialysis resident. R76's Admission Record dated 8/25/14, identified diagnoses including history of traumatic brain injury and dementia with behavioral disturbance.	F 309	with dialysis providers along with review of care plans for residents attending dialysis. 3 Audits per week x 4 weeks. Audit of EMAR/ETAR for correct signatures 2 audits per week x 6 weeks Audits will be completed to assure bathing preferences are met and care plan updated if refusal of baths is indicated a minimum of quarterly. Policy and Procedure for providing care per plan of care referred to QA The facility alleges that it will be in substantial compliance and complete all action items by: 02/29/16	

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 _____	02/01/2016

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 309	Continued From page 62	F 309		

R76's quarterly MDS dated 1/7/16, identified R76 had long and short-term memory loss, had no behavioral symptoms, and did not exhibit rejection of care.

R76's care plan dated 1/14/16, identified R76 had impaired cognitive function/dementia. The care plan directed staff to provide R76 with necessary cues, stop and return if agitated, break tasks into one step at a time, and to communicate with resident/family regarding residents capabilities and needs. R76's did not indicate the resident had behaviors related to rejection of cares.

During observation and interview on 1/25/16, at 12:10 p.m., R76 and family member (FM)-P stated R76 had not had a shower for two weeks, although he preferred to shower at least once a week.

During a follow up interview on 1/26/16, at 7:00 p.m., R76 stated he still had not been offered a shower.

R76's Body Audit Form dated 9/14/15, through 1/28/16, identified only 8 baths were provided, with only one documented refusal, and the last bath R76 received was on 1/12/16, 16 days prior.

During interview on 1/27/16, at 6:30 a.m. NA-C stated R76 often refused his bath and would sometimes get aggressive, but staff would try to reapproach R76 later. NA-C stated he would sometimes ask R76's family members to help with suggestions to complete R76's bath, however, he was not aware of any specific interventions in place for R76. NA-C stated R76 refused his bath last week, but was on the

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 _____	02/01/2016

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 309	Continued From page 63 schedule for later today. During a follow up interview on 1/27/16, at 2:41 p.m. FM-P stated R76 had still not had a bath. FM-P stated she was aware R76 sometimes refused his baths, but she had talked to the staff many times about approaches that have worked well with R76, such as giving him choices as to what time would work best, and stated R76 really liked certain staff members and he would not hesitate to take a bath when they approached him. Although R76 had not had a bath since 1/12/16, FM-P stated none of the staff had talked to her about R76 refusing to bathe or asked for her assistance, nor had the facility made staff aware of interventions that could be used for R76's behaviors while bathing. During a follow up interview on 1/28/16, at 8:09 a.m. NA-C stated R76 refused his bath yesterday, but he hadn't documented it anywhere or told the nurse. NA-C stated he would usually talk to FM-P when R76 refused his bath, however, he did not talk to FM-P yesterday. During interview on 1/28/16, at 12:28 p.m. RN-B stated she was not aware R76 had not received a bath since 1/12/16, but was aware he sometimes refused his bath. RN-B stated she was aware R76 would bathe and have less behaviors when approached by different staff members or when approached in different ways, however, the facility did not complete an assessment or develop interventions to ensure all staff were aware of how to deal with R76's behaviors and/ or refusals of care. A policy was requested for comprehensively assessing and developing interventions to assist	F 309		

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 _____	02/01/2016

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 309	Continued From page 64 residents that are resistive to cares, but was not received.	F 309		
F 311 SS=E	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure assistance was provided for 1 of 3 residents (R39), who required supervision and staff assistance with eating. In addition, the facility failed to ensure bathing was completed for 5 of 6 residents (R80, R84, R59, R76, and R86) who required staff assistance with bathing. Findings include: R39's quarterly Minimum Data Set (MDS) dated 12/21/15, identified R39 had long and short-term memory loss, and required supervision with eating. R39's care plan dated 1/6/16, identified R39 required staff assistance to eat. The nursing assistant care sheet titled Rosewood Group 2, undated, noted under diet pureed - may have soft snack as desires. There was no indication of how much staff assistance R39 required for meals.	F 311	F311 It is the Policy of Talahi Nursing and Rehab Center that all residents are given the appropriate treatment and service to maintain or improve his or her abilities. R 39 is assessed for the need for assistance with eating.-OT evaled R39 care plan was reviewed and updated, Group Care Card reviewed and Updated. Policy for providing feeding assistance was reviewed and is current R80, R84, R59, R76, R86 are assessed for the need for assistance with bathing. R80, R84, R59, R76, R86 care plans were reviewed and updated, Group Care Card reviewed and Updated. Bathing Policy is reviewed, revised and current Education was provided to direct care staff on assisting residents with eating, feeding assistance policy. Education was provided to direct care staff on assistance with bathing, bathing policy. Policy and Procedure for providing care per plan of care referred to QA	3/4/16

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 _____	02/01/2016

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 311	Continued From page 65 On 1/28/16, at 8:29 a.m. R39 was brought to the dining room, and placed at the dining room table. The resident had a lap tray on her wheelchair, which prevented the wheelchair from going underneath the table. At 8:52 a.m., R39's breakfast was placed on the dining room table, out of reach of R39. At 8:54 a.m. nursing assistant (NA)-C placed a bowl of oatmeal on the tray table with a spoon, encouraged R39 to eat , and handed her a glass of chocolate milk, which she drank independently, and then started to pour the chocolate milk into her oatmeal. NA-C who saw this, stated "Oh, what did you do", but continued to assist R39's tablemate. NA-C did not assist R39 with eating, then left the dining room. R39 remained at the table, with the biscuit, eggs, and gravy along with beverages out of reach on the dining room table. At 9:08 a.m. NA-B entered the dining room, placed the clothing protector on R39, cleaned up the chocolate milk from the tray, and placed the plate on her tray, and left the area without assisting R39 to eat. R39 made no attempt to eat independently at this time. At 9:12 a.m. NA-D entered the dining room, sat and assisted R39 to eat a couple bites, and left. From 9:12 a.m. until 9:29 a.m. R39 made no attempts to eat independently nor was she prompted by staff. At 9:29 a.m. NA-D returned to the dining room and assisted R39 to eat before removing her from the dining room at 9:35 a.m. R39 drank the remaining half glass of chocolate milk and ate 75% of the food on her plate with NA-D's assistance. When interviewed on 1/26/16, at 2:43 p.m. family member (FM)-L stated when she comes to visit during the evening meal, R39 was often sitting at	F 311	5 meal observation Audits per week x 6 weeks will be completed to assure staff are providing assistance to residents in need of assistance with eating per care plan. 5 bathing Audits will be completed weekly x 6 weeks to ensure bathing assistance is provided per Resident preference and care plan The facility alleges that it will be in substantial compliance and complete all action items by: 03/04/16	

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 _____	02/01/2016

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 311	Continued From page 66 the dining room table and not receiving staff assistance to eat. When interviewed on 1/28/16, at 11:42 a.m. NA-C stated R39 typically eats independently, and was not aware assistance was needed. NA-C also stated the nursing assistant care sheet does not indicate R39 required assistance with eating. When interviewed on 1/28/16, at 11:53 a.m. NA-B stated R39 was able to eat at times independently, however, she will often stop and required staff assistance. She also stated staff were to be sitting at the table with R39 throughout the meal, and this morning when she entered the dining room, there was no staff assisting her. NA-B stated assistance required should be noted on the nursing assistant care sheet, but this was not identified for R39. When interviewed on 2/1/16, at 8:11 a.m. RN-B stated R39's care plan identified having staff assisting during meals, and the nursing assistant care sheet should also indicate a need for assistance with meals. RN-B verified this was missing from the care sheet. Review of the Facility policy titled ADL [Activities of Daily Living] Policy review date 10/13, identified all staff will follow care plans and provide assistance with ADL's. R84's Admission Record dated 6/9/15, included diagnoses of dementia without behavioral disturbance, Alzheimer's disease, and osteoarthritis in both hands.	F 311		

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 _____	02/01/2016

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 311	Continued From page 67	F 311		

R84's quarterly Minimum Data Set (MDS) dated 12/29/15, identified R84 had severe cognitive impairment, and required limited assistance of one staff for personal hygiene, dressing, and bathing.

R84's care plan, dated 12/28/15, indicated R84 had an activities of daily living (ADL) self-care performance deficit related to dementia. Interventions included, "[R84] is able to: wash upper extremities independently, needs assist with lower extremities and shoes and socks."

The facility form titled East Baths, undated, identified (hand written in) R84 was to have three baths per week per family request. The baths were scheduled for Monday, Wednesday, and Friday.

Review of R84's Body Audit Form dated 12/4/15, through 1/28/16, identified R84 only received 7 baths, dated 12/4/15, 12/16/15, 12/17/15, 12/23/15, 12/29/15, 1/9/16, and 1/12/16, however, should have received approximately 21 baths during the time frame.

During interview on 1/28/16, at 8:09 a.m. nursing assistant (NA)-C stated The goal was to make sure everybody gets at least one bath each week, and the bath aide was scheduled Monday through Friday on the day shift, but was often pulled to work on the floor when staffing was short. NA-C stated baths were not being completed due to lack of staffing, and verified R84's Body Audit Forms were accurate and the dates listed were the only baths R84 had received during that time frame. NA-C indicated baths are completed only on the day shift during the week, so if a resident's bath is not completed on their scheduled day,

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 _____	02/01/2016

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 311	Continued From page 68 they try to add it to the next day, but that doesn't always happen. R80's quarterly MDS dated 1/1/16, identified R80 had severe cognitive impairment, and required limited assistance for bathing. R80's care plan dated 1/6/16, identified R80 required extensive assistance with bathing 1-2 times per week and as needed (prn). The facility form titled East Baths, undated, identified R80's baths were scheduled for Wednesday and Friday. R80's Body Audit Form dated 11/6/15, through 1/28/16, identified R80 received 6 baths during the time frame, however, the resident should have received approximately 24 baths according to the bathing schedule. During an interview on 1/28/16, at 8:09 a.m. NA-C stated the goal was to make sure everybody gets at least one bath each week, however, the bath aide was scheduled Monday through Friday on the day shift, and was often pulled to work on the floor when staffing was short. NA-C stated R80's Body Audit Forms were accurate and the dates listed were the only baths R80 had received during that time frame. R59's quarterly MDS dated 12/16/15, identified R59 had moderate cognitive impairment, and required limited assistance for bathing. R59's care plan dated 12/30/15, identified R59 required extensive assistance with bathing 1-2 times per week and prn.	F 311		

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 _____	02/01/2016

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 311	Continued From page 69 The facility form titled East Baths, undated, identified R59's baths were scheduled for Monday and Thursday. R59's Body Audit Form dated 9/14/15, through 1/28/16, identified 8 baths were provided during the time frame, however, the resident should have received approximately 34 baths during the time frame according to the bathing schedule. During an interview on 1/28/16, at 8:09 a.m. NA-C stated residents should be getting at least one bath a week, however, the bath aide was scheduled Monday through Friday on the day shift, but was often pulled to work on the floor when staffing was short. NA-C stated the Body Audit Forms for R59 was accurate and the dates listed were the only baths R59 had received during that time frame. R76's quarterly MDS dated 1/7/16, identified R76 had severe cognitive impairment, and required limited assistance for bathing. R76's care plan dated 1/14/16, identified R76 required extensive assistance with bathing 1-2 times per week and prn. During observation and interview on 1/25/16, at 12:10 p.m., R76 and family member (FM)-P stated R76 had not had a shower for two weeks, although he preferred to shower at least once a week. The facility form titled East Baths, undated, identified R76's baths were scheduled for Tuesday and Thursday.	F 311		

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 _____	02/01/2016

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 311	Continued From page 70 R76's Body Audit Form dated 9/14/15, through 1/28/16, identified 8 baths were provided during this time frame, however, R76 should have received approximately 35 baths according to the bath schedule. During interview on 1/27/16, at 6:30 a.m. NA-C verified the Body Audit Forms were accurate and the dates listed were the only baths R76 had received during that time frame. NA-C stated R76 often refused his bath and would sometimes get aggressive, but staff would try to reapproach later. NA-C stated he would sometimes ask R76's family members to help with suggestions to complete R76's bath, however, he was not aware of any specific interventions in place for R76. NA-C stated R76 refused his bath last week, but was on the schedule for later today. During a follow up interview on 1/27/16, at 2:41 p.m. FM-P stated R76 had still not had a bath. FM-P stated she was aware R76 sometimes refused his baths, but she had talked to the staff many times about approaches that have worked well with R76, such as giving him choices as to what time would work best, and stated R76 really liked certain staff members and he would not hesitate to take a bath when they approached him. Although R76 had not had a bath since 1/12/16, FM-P stated no staff had talked to her about R76 refusing to bathe or asked for her assistance, nor had the facility made staff aware of interventions that could be used for R76's behaviors while bathing. During a follow up interview on 1/28/16, at 8:09 a.m. NA-C stated R76 refused his bath yesterday, but he hadn't documented it anywhere or told the	F 311		

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 _____	02/01/2016

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 311	Continued From page 71	F 311		

nurse. NA-C stated he would usually talk to FM-P when R76 refused his bath, however, he did not talk to FM-P yesterday.

R86's admission MDS dated 12/7/15, identified R86 had severe cognitive impairment, and required limited assistance for bathing.

R86's care plan dated 12/16/15, identified R86 required extensive assistance with shower 1-2 times weekly and prn. It also noted "likes to shower frequently."

During an interview on 1/27/16, at 2:14 p.m., FM-P stated, "There is no excuse [R86] is not getting her baths because she is cooperative and likes her baths. I had to leave a note the other day to remind them to give her a bath."

The facility form titled East Baths, undated, identified R86's baths were scheduled for Monday and Thursday.

R86's Body Audit Form dated 12/3/15 through 1/25/16, identified 8 baths were provided during the time frame, however, the resident should have received 14 baths according to the bath schedule.

During an interview on 1/28/16, at 8:09 a.m. NA-C verified the Body Audit Forms for R86 were accurate and the dates listed were the only baths R86 had received during that time frame.

During an interview on 1/28/16, 8:49 a.m. RN-B stated every resident should receive at least one bath each week, although the goal was for each resident to receive two. RN-B stated when they are short staffed, the bath aide is required to help

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 _____	02/01/2016

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 311	Continued From page 72 on the floor to assist with resident cares, and baths are not getting completed. A policy for bathing was requested but not provided.	F 311		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure timely assistance with toileting, and assistance with oral care and shaving for 1 of 8 residents (R39) reviewed for activity of daily living assistance. The facility also failed to ensure bathing was completed for 1 of 7 residents (R81) reviewed for bathing. Findings include: R39's quarterly Minimum Data Set (MDS) dated 12/21/15, identified R39 had severe cognitive impairment, required extensive assistance for toileting and grooming, was always incontinent of stool, and frequently incontinent of bladder. R39's care plan dated 1/6/16, identified R39 was at risk for infection due to bladder and bowel	F 312	F312 It is the policy of Talahi Nursing and Rehab Center that all dependent residents are provided ADL□s consistent with their level of care needs. Residents R 39, R80, R 84, R 59, R 81, R 76, R 63 were assessed for and care plans were reviewed for bathing needs, toileting needs, oral care needs and shaving needs. Education was provided to staff on following the care plan and providing care according to the care plan. Education was provided on completion of bathing sheets was done with the staff assisting with bathing. Education was provided to direct nursing care on the assessment and care planning process. Policy and Procedure for providing care per plan of care referred to QA	3/4/16

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 _____	02/01/2016

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 312	Continued From page 73 incontinence, and instructed staff to offer toileting every two hours and PRN (as needed), and if refused, to check and change the resident. R39's Bowel and Bladder Quarterly Review dated 12/19/15, identified R39 was immobile, and was never aware of the need to toilet. During continuous observation on 1/28/16, from 8:11 a.m. through 10:55 a.m. (two hours and 44 minutes) R39 was seated in her chair in the hallway, brought to the dining room for breakfast, and then taken to an activity; R39 was not offered toileting or assisted with having her incontinent pad checked or changed. At 10:55 a.m. R39 was brought to her room and offered toileting, and R39 was assisted by nursing assistant (NA)-E to sit on the toilet. R39's incontinent pad was soiled with a medium amount of urine and contained a large amount of stool, and R39 did not go to the bathroom when she was on the toilet. When interviewed at this time, nursing assistant (NA)-E stated she was not aware the last time R39 had been toileted or had her incontinent pad changed, but stated R39 was to be toileted every two hours. During interview on 2/1/16, at 8:29 a.m. registered nurse (RN)-B stated R39 was to be offered toileting every two hours and as needed per the care plan, and it would not be acceptable for R39 to go two hours and 44 minutes without being offered toileting. A facility policy related to incontinence was requested, but none was provided. R39's quarterly Minimum Data Set (MDS) dated	F 312	5 Audits per week x 6 weeks on following the care plans r/t bathing, toileting, oral care and shaving . The facility alleges that it will be in substantial compliance and complete all action items by: 03/04/16	

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 _____	02/01/2016

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 312	Continued From page 74	F 312		

12/21/15, identified R39 severe cognitive impairment, and required extensive assistance for personal hygiene (including brushing teeth and shaving).

R39's care plan dated 1/6/16, identified R39 required assistance to maintain adequate oral hygiene, and instructed staff to swab her mouth with toothette twice daily.

During observation on 1/25/16, at 10:53 a.m. R39 had multiple, visible, facial hairs on her chin. During subsequent observation on 1/26/16, at 6:41 p.m. R39 continued to have the visible facial hair on her lower chin.

During observation of morning cares on 1/27/16, at 8:01 a.m. NA-F assisted R39 with her morning cares, including bringing dentures to R39 and placing them in her mouth, however, NA-F did not clean R39's mouth before placing the dentures in her mouth, nor did she offer to remove R39's visible facial hair.

When interviewed on 1/26/16, at 2:43 p.m. family member (FM)-L stated she had noticed R39's facial hair before, and stated staff should be removing this.

During interview on 1/29/16, at 2:10 p.m. nursing assistant (NA)-C stated residents should be offered shaving with their baths, and daily if hair is noticed. NA-C stated R39 had a bath the day prior, 1/28/16, however, shaving must have been missed.

When interviewed on 2/1/16, at 8:29 a.m. RN-B stated staff are to follow R39's plan of care for oral hygiene and offer to shave all residents daily

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 _____	02/01/2016

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 312	Continued From page 75 if they notice facial hair. A facility policy titled ADL [Activities of Daily Living] dated 10/13, identified all staff will follow care plans and provide assistance with ADL's as directed. R81's quarterly Minimum Data Set (MDS) dated 1/8/16, identified the resident had severe cognitive impairment, and required extensive assist with bathing. R81's care plan dated 1/20/16, identified R81 required extensive assistance with bathing 1 - 2 times per week and PRN (as necessary). An undated form titled East Baths listing, identified R81 was scheduled for a bath on Monday and Thursday each week. R81's Body Audit Forms dated 9/9/15 through 1/26/16, identified R81 received baths on 9/9/15, 9/14/15, 9/28/15, 10/1/15, 12/6/15, 1/5/16, 1/13/16. The resident should have received approximately 40 baths, however, was noted to only have received 7 baths during the time frame. During interview on 1/28/16, at 8:09 a.m., nursing assistant (NA)-C stated the goal was to make sure all residents get at least one bath each week. NA-C stated the bath aide was scheduled Monday through Friday on the day shift, however, was often pulled to work on the floor when staffing was short. NA-C verified the Body Audit Forms were accurate and the dates listed were the only baths R81 had during that time frame. NA-C stated baths were completed only on the day shift during the week, so if a resident's bath is	F 312		

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 _____	02/01/2016

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 312	Continued From page 76 not completed on their scheduled day, they try to add it to the next day, however, that doesn't always happen. During interview on 1/28/16, at 8:49 a.m. registered nurse (RN)-B stated every resident should receive at least one bath each week, although the goal was for each resident to receive two. RN-B stated there were a couple of nursing assistants who worked the evening shift that were, "Comfortable using the tub," but bathing was the responsibility of the bath aide on the day shift. RN-B stated if there is a call in the bath aides get pulled to work on the floor and bathing does not get completed. A policy for bathing was requested, but none was provided.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure timely repositioning, and a comprehensive assessment was completed for 2 of 2 residents (R37 and	F 314	F314 It is the policy of Talahi Nursing and Rehab Center that all residents receive comprehensive assessments to	3/4/16

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 _____	02/01/2016

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 314	Continued From page 77 R39) at risk for developing pressure ulcers. Findings include: R39's quarterly Minimum Data Set (MDS) dated 12/21/15, identified R39 had severe cognitive impairment, was "rarely/never understood", required extensive assist with transfers and bed mobility, and was at risk for pressure ulcer development. R39's Care Area Assessment (CAA) dated 7/3/15, identified R39 had a history of pressure ulcers, with risk factors including immobility, incontinence, and required staff assistance with bed mobility and transfers. R39's Comprehensive Skin Risk Factors form dated 12/16/15, identified R39 was immobile, had decreased sensory perception, required assistance with activities of daily living, and was at risk for sheer and friction. R39's care plan dated 1/6/16, identified R39 was at risk for impaired skin integrity, and instructed staff to turn, reposition, or offload every two hours for at least one minute and as needed. During continuous observation on 1/28/16, from 8:11 a.m. through 10:55 a.m. (two hours and 44 minutes) , R39 was observed sitting in her chair in the hallway, was brought to the dining room for breakfast, brought back to the hallway, and taken to an activity, without being offered repositioning. At 10:55 a.m. R39 was assisted by nursing assistant (NA)-E with sitting on the toilet. R39's incontinent pad was soiled with medium amount of urine and contained a large amount of stool.	F 314	determine skin risks and that a comprehensive care plan including interventions to prevent and treat pressure ulcers is developed. R39 was comprehensively re assessed for skin risk. R39 care plan was reviewed and is current. R37 was comprehensively re assessed for skin risk. R37 care plan was reviewed and is current. All inflatable cushions sited in the survey have been removed and disposed of. Facility wide audit was conducted to assure all air cushions are inflated correctly The policy for the prevention and treatment of Pressure ulcers/skin breakdown has been reviewed and is current The policy and procedure for evaluation of skin risk was reviewed and is current Education was provided to clinical staff on the policy and procedure for the prevention of pressure ulcers/skin breakdown Education was provided to clinical staff on the use of air/inflatable seat cushion and monitoring routine for correct air pressure. Policy and Procedure for skin monitoring and prevention of pressure ulcers referred to QA Facility will complete 3 audits per week x 6 weeks, audit to include review of assessments for potential for skin breakdown and care planning. Assessments/care plans will be reviewed a minimum of quarterly.	

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 _____	02/01/2016

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 314	Continued From page 78 When interviewed at this time, NA-E stated she was not aware of the last time R39 was repositioned, and stated R39 was to be toileted and repositioned every two hours. When interviewed on 2/1/16, at 8:29 a.m. registered nurse (RN)-B stated R39 was to be repositioned or offloaded every two hours and as needed per the care plan, and it would not be acceptable for R39 to go two hours and 44 minutes without being repositioned. R37's quarterly MDS dated 11/3/15, identified R37 had severe cognitive impairment, required limited assist with transfers, extensive assist with bed mobility, was at risk for pressure ulcer development, and had a stage II pressure ulcer (partial thickness skin loss), which developed 6/24/15. R37's pressure ulcer CAA dated 5/22/15, indicated R37 required a special seat cushion to reduce or relieve pressure, had a diagnosis of dementia which affected her ability to be independent, and required staff assistance. R37's care plan dated 11/18/15, identified the resident had recurrent pressure ulcer(s) to the bilateral gluteal folds, with interventions including a pressure relieving cushion to the recliner and standard chair in the dining room, as well as reposition or offloading for at least one minute every two hours. R37's Weekly Wound Assessment dated 1/20/16, identified the resident had a Stage II pressure ulcer to the right inner gluteal fold/buttock, measuring 5 cm x 1 cm x 1 cm which was	F 314	The facility alleges that it will be in substantial compliance and complete all action items by: 03/04/16	

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 _____	02/01/2016

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 314	Continued From page 79 identified on 6/24/15. During observation on 1/27/16, at 12:22 p.m. RN-B assisted R37 to the bathroom, and performed a wound assessment to the pressure ulcer on the right buttock. RN-B identified R37's pressure ulcer was a stage II, and measured 0.4 x 0.1. During multiple observations on 1/25/16, at 10:44 a.m. on 1/26/15, at 6:58 p.m., on 1/27/16, at 7:23 a.m. and on 1/28/16, at 9:52 a.m. R37 was seated on a light blue cushion in the recliner in the commons area. R37 sat on the front half of the cushion, which was flat against the chair, with the air in the cushion all pushed to the back of the cushion behind her buttock. When interviewed on 1/25/16, at 11:02 a.m. RN-B stated R37 had a Stage II pressure ulcer to the right buttock, which has been recurrent the last two years. When interviewed on 1/27/16, at 12:22 p.m. RN-B stated R37 has had these blue cushions, but was not aware for how long. RN-B stated the cushions are not reinflatable. When interviewed on 1/27/16, at 1:07 p.m. occupational therapist (OT)-A observed the Striker Sof Care cushion in the recliner, and stated the air was low in the cushion and it was flat, and would not be effective to use for pressure relief. OT-A stated the cushion was not able to be reinflated, and OT would not recommend this type of cushion for pressure relief. At this time OT-A observed R37 in the dining room sitting on the cushion in the chair, and stated there was no benefit from the cushion	F 314		

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 _____	02/01/2016

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 314	Continued From page 80 as all of the air present was pushed to the back of the cushion behind R37's buttock. During follow up interview on 1/29/16, at 1:20 p.m. OT stated no documentation was available from therapy indicating the origin of use of the cushion for R37, nor had R37 been referred to therapy for assessment of pressure relieving devices. When interviewed on 2/1/16, at 8:43 a.m. RN-B stated there would be no benefit from the cushion if there were no air in them to help to relieve the pressure. RN-B also stated she was not aware where the cushion came from, and stated a more thorough assessment should have been completed to ensure an appropriate device was being used to relieve pressure to R37's buttocks. A Facility policy regarding pressure ulcer / skin care was requested but not provided.	F 314		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess and develop interventions to reduce the	F 323	F323 Rejection Reason: what about other residents who had the potential for the	3/11/16

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 _____	02/01/2016

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 323	Continued From page 81 risk of significant harm to 1 of 1 residents (R77) who was consuming alcohol and becoming intoxicated which resulted in multiple episodes of medical and/or detox intervention. This resulted in an immediate jeopardy situation for R77. In addition, the facility failed to comprehensively assess the safe use of hot coffee to determine if further interventions were required for 1 of 1 residents (R31) who spilled hot coffee on herself. The facility also failed to asses the safety of 1 of 1 residents (R70) who was leaving the facility without supervision or staff knowledge. Findings include: The immediate jeopardy began on 1/28/16, when it was identified R77's safety was at immediate risk due to multiple incidents of intoxication resulting in medical and detox intervention related to becoming intoxicated and exhibiting unsafe behavior. Although the facility was aware of R77's significant lack of safety awareness for himself and others, the facility failed to comprehensively assess and implement interventions of R77's ongoing excessive use of alcohol with intoxication. On 1/28/16, at 5:58 p.m. the facility administrator, director of nursing (DON), and facility nurse consultant were notified of the immediate jeopardy (IJ) for R77. The IJ was removed on 2/1/16, at 1:38 p.m. but noncompliance remained at an isolated scope and severity level, which indicated actual harm that is not immediate jeopardy (Level G). R77's annual Minimum Data Set (MDS) dated 12/14/15, identified R77 had medical diagnoses which included anxiety and manic depression, had no memory impairment and made, "Consistent/reasonable," decisions in daily tasks.	F 323	same issues. Were they re-assessed? Need system wide correction It is the policy of Talahi Nursing and Rehab Center that all resident environments will remain free of accident hazards as is possible and that each resident receives adequate supervision and assistance devices to prevent accidents. R 77 no longer resides at the facility. R 31 was provided a covered cup with meals and OT evaluated for the use of adaptive equipment and care plan updated. R 70 was educated on the need for oxygen and was given a risk and benefits agreement and care plan was updated. R 70 primary MD was updated. Audit of current Residents by Social Services for indicative triggers for risk of harm to self or others is completed. Social Services Admission process and comprehensive assessment content reviewed and revised to include indicative triggers for risk of harm to self or others. DON, or designee to Audit daily, incident reports and care planning of immediate interventions to ensure compliance of staff. Incidents to be discussed at daily IDT, including care planning/interventions to ensure adequate interventions have been put into place. All Residents that leave facility independently re-assessed for safety to do so. Elopement Policy reviewed and is current Elopement Risk identification Procedure including screening assessments, post	

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 _____	02/01/2016

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 323	Continued From page 82 The MDS identified R77 demonstrated no behaviors which put himself or others at risk for injury, and was independent with activities of daily living (ADLs). Although R77 was noted in the progress notes on 12/7/15, within the 7 day look back assessment period, to have left the facility and return intoxicated, the MDS assessment did not identify the resident had behaviors which put himself or others at risk for injury. R77's Admission Record dated 1/28/16, indicated an original admission date of 9/15/14, with a current admission date of 7/2/15. R77 had diagnoses including Alcohol Abuse with Unspecified alcohol-induced disorder, major depressive disorder, and anxiety disorder. During observation on 1/26/16, at 10:00 a.m. R77 walked up to the mobile medication cart outside the dining room and began to pace up and down the hall while waiting for the nurse to visit with him. R77 then went outside and smoked a cigarette before coming back in to speak with the nurse, however, licensed practical nurse (LPN)-B was still conversing with another resident, so R77 stood there tapping his hand on his cane for a few minutes until the nurse was able to visit with him. During observation on 1/28/16, at 4:39 p.m. R77's room door was closed. R77's Safety Risk Data Collection assessments dated 2/20/15, to 9/11/15, were reviewed and identified the facility had completed six Safety Risk Data Collection assessments during that time period. R77 had internal risk factors for falls which included hypertension, pain, impaired hearing, and anxiety. R77 used half side rails on	F 323	Elopement Assessment, development of preventive CP interventions in process. Facility wide audit to identify other residents at risk for injury r/t hot liquid spills.¿ Utilization and integration of Safety Data collection for hot liquids assessment at admit, quarterly, sig change to facility implementation of accurate care plan. Assessment/evaluation and care planning process referred to QA. Education provided to direct nursing caregivers on the assessment and care planning process. Education was provided to staff on the prevention of accidents and vulnerable adult reporting along with when to fill out an incident report. Audits will be completed weekly on occurrence reports for VA reporting along with assuring follow up was completed along with assuring the care plan was updated with a new intervention. The facility alleges that it will be in substantial compliance and complete all action items by: 03/11/16	

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 _____	02/01/2016

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 323	Continued From page 83	F 323		

his bed secondary to pain, and had good wheelchair positioning. R77 was identified as having a history of aggressive and abusive behaviors. The bottom of all six assessments contained a field to include a, "Summary of Data collected," however, this portion of the assessment was blank. None of the provided Safety Risk Data Collection assessments identified any information on R77's past or current alcohol use, including if he was safe to leave the facility and consume alcohol, any potential risks for withdrawal from alcohol, or potential aggression towards staff and/or residents resulted from consuming alcohol despite being identified upon admission has having a history of alcohol abuse.

R77's Vulnerability Assessment dated 9/15/14, identified R77 had a vision impairment, and used a wheelchair for mobility. R77 had bipolar depression and anxiety, but displayed no identified behaviors. Although R77 was identified upon admission as having a diagnoses of alcohol abuse, R77's Vulnerability Assessment lacked any further assessment regarding R77's past or current alcohol use including if he was safe to leave the facility and consume alcohol, signs or symptoms of alcohol withdrawal staff should be monitoring for, or potential aggression towards staff and/or residents resulting from consuming alcohol.

R77's Elopement Risk Assessment dated 9/18/15, identified R77 was, "Ambulatory or self-mobile in wheelchair," and had no identified concerns for poor decision making skills, or not being compliant with established facility protocols and policies regarding leaving the unit. The assessment did not identify any information on

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 _____	02/01/2016

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 323	Continued From page 84 R77's past or current alcohol use, including if he was safe to leave the facility and consume alcohol, any potential risks for withdrawal from alcohol, or potential aggression towards staff and/or residents resulted from consuming alcohol. R77's care plan dated 1/24/16, identified R77 had, "A behavior problem," and was, "Noted to consume alcohol and become intoxicated." The care plan identified a goal for R77 of, "Will have fewer episodes of being intoxicated by review date," and listed interventions for R77 including, "Intervene as necessary to protect the rights and safety of others," "when [sic] resident leaves facility upon return ask resident if he has alcohol in his possession," and, "Update MD as needed in regards to resident's continued alcohol consumption." The care plan did not identify what interventions staff should attempt if R77 was found to have alcohol in his room or on him, if he was assessed to be safe to consume alcohol, any behaviors R77 demonstrated while consuming alcohol, direction on how to handle any potential withdrawal symptoms for R77, or how to ensure he and others were kept safe if R77 was found to be consuming alcohol. Further, R77's care plan directed staff to serve all meals on disposable dishes, "To prevent using dishes or utensils as a weapon." During observation of meal service on 1/28/16, at 4:41 p.m., R77's table setting was observed to have a paper plate and plastic cutlery sitting on the table. All of the other residents in the dining room were provided with metal utensils and ceramic dishes. When interviewed on 1/28/16, at 4:41 p.m., dietary aide (DA)-A stated he was unsure why R77 used paper and plastic cutlery.	F 323		

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 _____	02/01/2016

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 323	Continued From page 85	F 323		

R77's progress notes dated 1/6/15, to 1/28/16, identified the following entries in which R77 left the facility unsupervised and consumed alcohol, or required police, medical, or detox care as a result of consuming alcohol:

On 1/16/15, R77's roommate was found yelling for help. R77 was found in his room, "Face down next to [his] bed." R77 was unresponsive, and alcohol could be smelt on his breath. Staff located two empty bottles of alcohol in R77's drawers, and three knives were found in his pocket, after R77 had threatened staff earlier in the shift that day. Police and Ambulance services were called, and R77 remained unresponsive when they arrived. R77 was transferred to the hospital via ambulance at 10:30 p.m.. On 1/17/15, at 4:00 a.m. the St. Cloud Hospital Emergency Department (ED) called the facility and stated R77's blood alcohol content was 0.22 and he was unresponsiveness, "Was probably due to that [alcohol consumption]." R77 returned to the facility at 6:55 a.m., alert and with his eyes open.

The corresponding hospital ED report was requested, but was not provided.

On 2/7/15, at 9:40 a.m. R77 was spoken to by facility staff after he was reported to have alcohol on him. R77 denied having any alcohol, nor anything to drink that day. R77 told staff, "I usually have some alcohol in the morning." R77's speech was slightly slurred during this interaction. At 11:43 a.m. facility staff contacted the St. Cloud Police Department as R77 was, "Noted to be verbally aggressive with staff." The facility staff removed one pint sized bottle of alcohol from his

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 _____	02/01/2016

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 323	Continued From page 86	F 323		

room, and it was locked in the medication room.

The corresponding police report was requested, but was not provided.

On 3/7/15, at 2:00 p.m. R77 was found intoxicated on the floor in his room. R77 required an abdominal dressing change from staff, but he became angry and started to yell into the hallway, at one point ripping off his dressing and, "Showing other residents." R77 attempted to physically strike the nursing staff, and the police were notified. The police remained at the facility for a period of time, "To ensure [R77] would not harm anyone, and left without taking [R77] in." Later that day at 7:30 p.m., staff found R77 with a ½ full bottle of alcohol in his room. R77 became combative with staff, and the ambulance and police were notified. R77 continued to verbally threaten staff adding, "Just you wait until I come back, you are gonna get it." R77 was transferred to the ED after having to be restrained by three police officers. Staff searched R77's room and located two empty bottles of alcohol. On 3/8/15, R77 returned from St. Cloud Hospital ED and staff discussed his alcohol use and threatening behaviors with him and R77 agreed to not drink alcohol while in the facility.

R77's corresponding hospital ED record report dated 3/7/15, identified R77 had been brought to the ED, "Because of intoxication and aggressive behavior." R77 admitted he had been drinking that day, and when questioned about alcohol consumption during his medical review, R77 stated he drinks, "As much as possible." R77's blood alcohol level was, "Elevated at 0.3," and the final diagnosis was listed as, "Alcohol intoxication, uncomplicated."

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 _____	02/01/2016

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 323	Continued From page 87 On 4/23/15, R77 left the facility on a leave of absence (LOA) from 3:30 p.m. to 6:30 p.m. to, "Buying things for his guitar." R77 returned to the facility and, "Seemed intoxicated." R77 was noted to be asking several other residents if they would like to drink alcohol with him and, "Making them [the other residents] extremely uncomfortable." Nursing staff went into R77's room and located a backpack which contained five bottles of alcohol, two of which were empty, and removed the bottles and stored them in the medication room. On 4/24/15, R77 was noted to have left the facility to go to the public library, "And came back drunk." R77 was identified as, "Too lethargic at HS [hour of sleep] to take his pills and couldn't comprehend what was going on." On 4/29/15, R77 was noted by staff as, "Being intoxicated during the day shift." R77 was still intoxicated and left the facility to go to the library at 3:00 p.m. and, "Was stumbling across parking lot and sidewalk as he walked to bus stop." R77 was returned to the facility by police later the same day at 6:30 p.m. The police had found R77, "Almost passed out in the library," and had noted he was drinking while at the library. In addition, the facility staff removed, "7 bottles of liquor from from [sic] room and locked them in med room. At least 4 were empty. They ranged in sizes from quart to pint to 8 oz [ounces] sizes." The staff removed these bottles from R77's room when he left the facility to go to the library and had already been noted to be intoxicated. On 5/20/15, R77 left the facility on a city bus at 4:00 p.m., and was found by staff outside the facility at 9:30 p.m. sitting on the pavement. R77	F 323		

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 _____	02/01/2016

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 323	Continued From page 88	F 323		

denied drinking, however, was noted by staff to be, "Slurring his speech," and had difficulty making out words, or speaking clearly.

On 6/2/15, the progress notes indicated R77 left the facility in the late afternoon of 6/1/15, with his personal backpack, and did not sign out per facility protocol. R77 returned to the facility at approximately 7:00 p.m. on 6/1/15, and went to his room. The staff attempted to provide bed time medications at approximately 9:00 p.m. and R77 was, "Unable to make eye contact w/ nonsensical words." R77's medications were wasted. Later on 6/2/15, at 2:49 p.m. R77 was noted to have bloodshot eyes and, "Alcohol could be smelled on his person."

On 6/25/15, R77 left the facility at 10:00 a.m. stating, "I am leaving for a while." R77 would not tell staff where he was going, "That's for me to know and you to not." On 6/26/15, at 1:36 p.m. (over 24 hours later) R77 still had not returned to the facility, nor made any contact with staff regarding his whereabouts. At 3:52 p.m. the St. Cloud Police Department contacted the facility and identified R77 had been arrested and transferred to the Sherburne County Jail in Elk River, MN due to having a warrant for his arrest. R77 would be released that day, and returned to the facility. The note identified, "[DON] and [administrator] updated on situation."

R77's corresponding Incident/Arrest Report dated 6/25/15, identified R77 had been picked up by the police department and was noted to have a razor, butter knife, and unopened bottle of brandy on him when arrested. R77 was found by police, "Laying next to war memorial," at Lake George, which was approximately 2 miles from the facility.

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 _____	02/01/2016

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 323	Continued From page 89 On 6/30/15, R77 became upset and accused staff of opening his magazines before he received them. R77 was swearing and, "Appears to be intoxicated." The nursing staff contacted the medical doctor (MD) and received orders to send him to the emergency room for his behaviors of threatening staff and other residents. An ambulance arrived to the facility at 11:10 a.m. and R77 began to yell at the ambulance crew that facility staff, "was stealing from him and that he does not need to go to the hospital." The police were notified and arrived at the facility. R77 continued, "Refusing to go [to] the ER for evaluation stating that he does not have to go and to call the paper as he is a member of ISIS to take care of things." R77 was removed from the facility by police at 11:50 a.m. At 3:40 p.m., facility staff documented R77 was, "Arrested and in jail at this time." R77 returned to the facility on 7/2/15, from St. Cloud Hospital. R77's corresponding hospital record report dated 6/30/15, identified R77 was brought to the ED via ambulance, "Because of the intoxication." R77 had been drinking alcohol and, "Has become belligerent, which subsequently led to a disorderly conduct charge." R77's breathalyzer was checked and was 0.23. The hospital indicated R77 could be discharged to Detox and/ or back to the facility, however, neither would accept his admission due to being unable to ambulate steadily on his feet. On 7/8/15, R77 was noted to be on, "LOA from 1600 [4:00 p.m.] to about 2030 [8:30 p.m.]. Resident returned intoxicated and was going into other [resident] rooms to talk to other residents that did not want him around." R77's medications	F 323		

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 _____	02/01/2016

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 323	Continued From page 90	F 323		

were held as, "Resident is intoxicated."

R77's Resident Release Form dated 7/6/15, to 1/2016, identified R77 did not sign out of the facility prior to leaving and returning intoxicated.

On 7/9/15, R77 left the facility at 11:00 a.m. and returned at 12:30 p.m. R77 did not report where he was going, and was "Noted to appear intoxicated and was slurring his words when speaking to staff and smelled of alcohol."

R77's Resident Release Form dated 7/6/15, to 1/2016, identified R77 did not sign out of the facility prior to leaving and returning intoxicated.

On 8/1/15, R77 was out of the facility, and staff last saw him at 8:30 a.m.. At 1:45 p.m. the St. Cloud police department contacted the facility and reported R77 had been, "Brought to ED [emergency department] due to intoxication." The hospital nurse reported R77 was brought to the ED, "After falling at bus stop with inability to get back up and incoherence." R77 sustained abrasions to his knees and thighs, and had a blood alcohol content of 0.39, and would be sent to Detox if a bed was available. At 10:36 p.m. R77 was returned to the facility via taxi cab due to no beds being available at Detox and, "Was still very intoxicated." R77 was unable to walk or stand on his own, and was assisted into the facility by staff at which time R77, "Saw another resident he began teasing him and hit him on the arm which upset the other resident." The progress note also identified R77 tried to convince that resident to come back to his room and continue drinking alcohol with him.

R77's corresponding hospital report dated

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 _____	02/01/2016

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 323	Continued From page 91	F 323		

8/1/15, identified R77 was, "Brought for evaluation with alcohol intoxication," after having fallen at the bus station. R77 had left the nursing home and was drinking alcohol and was found, "With a bottle of brandy." The medical doctor (MD) in the ED identified he was unable to obtain a complete review of R77, "Until he was less intoxicated." A blood alcohol content was completed and R77 had a blood alcohol level of 0.39. R77 was diagnosed with alcohol intoxication and a fall suffering a right knee abrasion, and discharged back to the facility with discharge instructions of, "He will need to be observed closely."

During review of R77's progress notes dated 8/1/15, through 8/3/15, no evidence was identified any specific actions were taken to monitor R77 for signs and symptoms of alcohol withdrawal, including breathing and potential delirium, as requested by the ED discharging physician.

On 8/3/15, at 9:30 a.m. R77 was observed by staff to, "Leave [the] building with backpack." At 3:45 p.m. R77 returned to the facility and, "Appeared to be intoxicated."

On 10/12/15, R77 left the facility with a friend at 4:30 p.m., and as of 10:11 p.m. had not returned. Nursing staff called St. Cloud police department and notified them, adding, "We have no way of Contacting [sic] him [R77]." A subsequent note dated 10/16/15, (4 days later) identified, "[R77] returned to facility at 0900 [9:00 a.m.] and stated he was helping a sick friend." Resident informed he should call and let facility know where he was and he laughed and stated, "Why would I do that?" R77 was absent from the facility, with staff unaware of his location or activities, from

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 _____	02/01/2016

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 323	Continued From page 92	F 323		

10/12/15, at 4:30 p.m. until 10/16/15 at 9:00 a.m. when he returned (nearly four days).

R77's Resident Release Form dated 7/6/15, to 1/2016, identified R77 did not sign out of the facility prior to leaving.

On 11/3/15, R77 was documented as leaving the facility around 3:00 p.m. the day prior, on 11/2/15. At 7:00 a.m. on 11/3/15, R77 had not returned to the facility. At 1:57 p.m. the facility noted, "Informed res [resident] was at detox, did speak with resident, does not know when he will return."

R77's corresponding hospital report dated 11/3/15, identified R77 was brought to the ED via ambulance. R77 was, "Found outside of a bank in the bushes," and could not stand and was intoxicated. He was felt to be very cold, as the temperature outside, "Did get down into the lower 40s." R77 stated he was drinking, but was unable to recall when his last drink was prior to coming to the ED. The ED medical doctor (MD) identified a diagnosis of, "Alcohol intoxication with hypothermia," and listed R77's breathalyzer was 0.2 when performed. R77 was to be discharged to Detox when able to stand using his cane again.

On 12/7/15, R77 left the facility at 6:25 p.m. and returned at 9:52 p.m. R77 was intoxicated upon his return to the facility, "Resident returned to facility, res [resident] noted to be intoxicated ..."

In addition to the above instances, R77's progress notes identified over 50 documented occurrences from 1/6/15, to 1/28/16, of R77 being found intoxicated, including eight times having to have his medications withheld, three times being found on the floor, nine times becoming verbally

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 _____	02/01/2016

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 323	Continued From page 93	F 323		

or physically aggressive with staff and/or residents, and six times having bottle(s) of full or consumed alcohol removed from his room.

Further, a listing of previous ED visits for R77 dated 11/3/15, identified R77 had been to the ED thirteen times since 8/3/13, for alcohol abuse and/or intoxication.

In addition, R77's Office Visit note, completed by a physician on 8/6/15, identified R77 appeared to be, "Going through some mild alcohol withdrawal," and the physician identified R77 had even been intoxicated when seen the week prior. R77 was prescribed narcotic pain medication, "But he must remain dry." 10/22/15, MD Office Visit Note identified R77 had a past medical history which included, "Alcoholism," and noted R77 had, "Multiple hx [history] of going through detox, multiple inpatient tx [treatment], and having withdrawal seizures and delirium tremors in the past."

During interview on 1/27/16, at 2:14 p.m. nursing assistant (NA)-N stated R77 would leave the facility and, "Sometimes come back drunk." The staff were able to smell the alcohol on him when he returns, and his gait was unstable. When R77 returned and was intoxicated, staff just helped him to his room and tell him to sleep, and, "Most of the time [R77] just passes out." NA-N was unaware of any specific interventions staff were to do for R77 if he was suspected or found to be drinking. R77 had a closet in his room which he kept locked and NA-N stated staff was unable to get into it, which is where they suspect he kept his alcohol. NA-N stated she believed R77 had to use plastic cutlery for his meals because he made a threat to stab the previous administrator.

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 _____	02/01/2016

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 323	Continued From page 94	F 323		

During interview on 1/27/16, at 2:22 p.m. NA-O stated R77 became angry at times when he drinks. NA-O stated had to remove bottles from his room before, most recently the beginning of January 2016. NA-O stated R77 would leave the facility and tell staff he was going to the library, and then he would return with alcohol. NA-O was unaware of any interventions the staff should be doing for R77 when he returned with alcohol or when he was intoxicated and stated, "He mostly just passes out." NA-O stated R77 used plastic cutlery because of threatening staff in the past with knives/ silverware he had gotten from the facility.

During interview on 1/27/16, at 2:30 p.m. NA-P stated R77 consumed alcohol, but was unsure how often or where. R77 had told staff before he, "Stashes" alcohol in his room, but NA-P had never personally found any containers or bottles. NA-P stated she was unaware how R77 was obtaining alcohol, and was unaware of any interventions staff was to do if R77 was found or suspected to be intoxicated.

During interview on 1/28/16, at 9:10 a.m. R77's county case worker (CW) stated she had been involved with R77 since September 2015, and was trying to help him find other housing services. CW had visited R77 multiple times, and on different occasions noted him to be intoxicated to the point he was incoherent, and being unable to recognize she was even present at the facility with him. CW had identified a pattern of R77 drinking more heavily towards the beginning of

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 _____	02/01/2016

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 323	Continued From page 95	F 323		

the month when he obtained his money from the government, and she had encouraged the facility to report R77 as a vulnerable adult due to his alcoholism and poor judgement.

During interview on 1/28/16, at 9:20 a.m. R77's primary medical doctor (MD)-K stated he was aware R77 was consuming alcohol, and added he had received several phone calls from the facility when R77 would be drinking alcohol, either at or away from the facility, and had behaviors and, "Acting strange." R77 was known to do what he wants to do, and had expressed desire to discharge the facility. MD-K stated R77 had been to his office for an appointment before while intoxicated, and added R77 should not be consuming alcohol but, "What are you going to do?" MD-K stated R77 does not take appropriate care of himself, and the, "Wall needs to be made higher," meaning to not make it acceptable and easy for the resident to be drinking.

During interview on 1/28/16, at 10:00 a.m. registered nurse (RN)-B stated R77 had left the facility and returned intoxicated before, and R77 should not be consuming alcohol as it was, "Not good for him." R77's mood and behavior was different each time he consumed alcohol, and sometimes R77 would be happy and friendly, but other times he would become completely incoherent and disruptive to other residents. R77 had an order from his physician which identified he should not leave the building except for medical appointments, however, R77 would leave anyway. RN-B stated the facility had never completed an assessment of R77 to determine if he was safe to consume alcohol unsupervised and to determine what interventions needed to be

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 _____	02/01/2016

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 323	Continued From page 96	F 323		

in place to ensure R77 was safe. RN-B stated staff asked R77 each time he returned to the facility if he had consumed alcohol, however, RN-B was not aware of any interventions for R77 besides trying to keep him isolated in his room if he was found to be intoxicated. RN-B stated R77 had his medications held on several occasions before due to being too intoxicated to safely take them. RN-B stated she was unsure of the exact date of the last time R77 had consumed alcohol, however, she stated it was sometimes within the past two weeks. RN-B stated might not be documenting each time R77 was identified as drinking alcohol or being intoxicated as it had become, "The normal."

During interview on 1/28/16, at 10:50 a.m. the facility licensed social worker (LSW)-A stated R77 received a physician order to not consume alcohol when he started his chemotherapy several month prior, but R77 continued to drink despite this as R77 did not feel his continued drink was a concern. LSW-A stated she was unaware if any assessment of R77's safety related to his excessive alcohol use had been completed, and stated she was unaware who in the facility would even complete such an assessment. LSW-A stated R77 could potentially be a danger to himself and she had not completed any assessment, or implemented any interventions to determine if the resident required any further services, and to determine if the resident and /or other residents were safe while R77 was intoxicated.

During interview on 1/28/16, at 1:35 p.m. the director of nursing (DON) stated the facility did

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 _____	02/01/2016

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 323	Continued From page 97	F 323		

not have any type of assessment completed regarding R77's ability to consume alcohol safely unsupervised as R77 was his own person. The nursing staff should be assessing R77 upon his return from an LOA if they suspect he was drinking, and using their own judgment to determine what further interventions should be provided, including if his medications can be safely administered. R77 had a physician order in place until 1/8/16, not to leave the facility except for medical appointments, however, it was discontinued because R77 was leaving anyway and continuing to consume alcohol. DON again stated the facility had not conducted an assessment to determine if R77 was safe to continue consuming alcohol despite his past history of alcohol abuse, repeated episodes of leaving the facility and returning intoxicated, and multiple episodes of requiring medical and/or Detox therapy because of his alcohol consumption.

During a follow up interview on 2/1/16, at 9:54 a.m. LSW-A stated she had been working closely with R77's case worker to discuss discharge options. LSW-A stated she was aware of R77's unsafe behaviors and his continued alcohol use, but stated, "He is his own person; he makes his own decisions." LSW-A stated she tried to find ways that they could stop R77's drinking, however, R77 didn't feel he had a problem with alcohol, so nothing was pursued. LSW-A stated she had spoken to R77's physician previously [about 6-7 months prior] about proceeding with possible commitment or 72 hold, however, she had not followed up to determine if this was an option.

Policies regarding the assessment of resident safety were requested, but none were provided

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 _____	02/01/2016

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 323	Continued From page 98 by the facility. After the facility was notified of the immediate jeopardy for R77 on 1/28/16, at 5:58 p.m. the facility implemented 1:1 staffing to be with R77, and also implemented a contract dated 1/28/16, which indicated, "I [R77] will not drink alcohol while I'm staying at Talahi and will be compliant with my plan of care. I will not leave the premises' unsupervised and will not put other resident and staff in danger. If this contract is violated, I am aware that I can be evicted, police will be notified, and may be sent to the hospital for further treatment, related to safety of self and safety of others." This was signed by the social worker and DON, however, R77, "Refused to sign." A corresponding progress note written by DON with a late entry dated 2/1/16, which occurred on 1/28/16, indicated, "At 1800 [6:00 p.m.] through staff observation and discussion with administrator, social services, HR [human resources], and staff nurses and nursing assistants and of reports of verbal outbursts and wanting to hit others, it was determined that to keep resident, other residents, and staff safe and free from harm, resident was deemed to be 1:1 until other placement could be obtained. Subsequently, resident made sexual, threatening verbal abuse toward staff member at which time 911 was called. Writer called and updated [MD]. Writer also called and updated [medical director] with residents current status. Physicians in agreement with call placed to 911. Resident was removed from facility by St. Cloud Police Department. A Physician Note dated 1/29/16, written by R77's	F 323		

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 _____	02/01/2016

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 323	Continued From page 99	F 323		

primary MD indicated, "It's been reported to me that recently [R77] threatened a male nursing assistant and two female assistants witnessed the incident. They felt threatened by him. Patient reportedly stated that he has raped five women and is looking for more. I am told the police were called. Patient is definitely a danger to others. He may be discharged from the nursing home. He cannot return to that facility because he is a danger to others."

During a follow up interview on 1/29/16, at 8:54 a.m. DON and administrator stated R77 had been discharged the prior evening, 1/28/16, at approximately 10:00 p.m., after threatening staff and telling a NA he had raped 5 people and he was looking for more. The DON stated the facility called the police, and the police arrested him due to a warrant out for his arrest. The DON stated the police did not inform the facility what the warrant was for, and the police did a breathalyzer on R77, and stated it, "Tested at a high level [for alcohol]," however, the facility was not made aware of what the residents alcohol level was. DON stated on 1/28/16, R77 had left the facility sometime earlier that day without any staff knowledge, and when he returned he stated he went to the social security office. DON was unaware if R77 returned to the facility intoxicated, or if he had been drinking in his room when he returned. After the resident was taken into police custody, the facility searched his room and found 3 empty bottles of brandy. Administrator stated R77 was notified he will be discharged from the facility.

The immediate jeopardy which started on 1/28/16, at 5:58 p.m. was removed on 2/1/16, at 1:38 p.m. after the facility completed the following

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 _____	02/01/2016

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 323	Continued From page 100 interventions as part of their removal plan: - R77 was assessed to be unsafe to consume alcohol, and was placed on 1:1 observation to ensure safety while in the facility. R77 was subsequently discharged to jail on 1/28/16. - R77's care plan was changed to reflect his assessed risks of consuming alcohol, and interventions put in place were added to ensure safety. - The facility assessed other identified residents at risk for consuming alcohol in an unsafe manner to ensure their safety, and their plan of care was updated. - The facility administration completed a review of resident safety policies, including, "Safety," and, "Careplan," and educated staff on revisions to process and procedure on ensuring the safety of residents with consumption of alcohol was assessed and interventions were care planned. - The facility provided R77 a Notice of Transfer or Discharge dated 1/29/16, which indicated, "This is to notify you that Talahi Nursing and Rehab Center, LLC will discharge you to the St. Cloud Police Department Immediately at 10:12 p.m. January 28, 2016. The reason for this discharge is: Not following facility policy and procedures by risking the safety of yourself and other residents and staff." On 2/1/16, from 10:40 a.m. to 11:06 a.m. direct care staff, including registerednurses, were interviewed regarding ensuring safety with alcohol consumption was assessed in a timely fashion, and adequate interventions to ensure safety of the resident were implemented. All of the interviewed staff were aware of the revised policies and procedures, as well as aware of assessing residents for safety and vulnerability's.	F 323		

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 _____	02/01/2016

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 323	Continued From page 101	F 323		

R31's Admission Record dated 9/1/15, identified diagnoses of dementia, other symptoms and signs involving cognitive functions and awareness, and a history of falling.

R31's quarterly MDS dated 12/18/15, identified R31 had severe cognitive impairment, required extensive assistance of one staff for toileting, required limited assistance with personal hygiene, and was independent with eating after set up.

R31's care plan dated 9/16/15, did not identify any concerns regarding her ability to safely eat/drink.

Review of R31's nursing progress notes dated 1/16/16, R31, "Spilled coffee on her bilateral inner thighs. Area was cleansed immediately. Skin at time of incident was red and raised."

During observation on 1/26/16, at 6:12 p.m. R31 was sitting at the table in the Rosewood dining room waiting for the supper meal to be served. R31 was given an uncovered plastic coffee cup 3/4 filled with coffee. R31 picked up the cup of coffee, pushed the chair back from the table, and ambulated down the hallway, carrying the cup. R31 was observed carrying the uncovered coffee cup to her room, and set the cup of coffee on the bedside stand. An empty coffee cup was also observed in her room on top of the dresser. R31 returned to the dining room, sat down in her chair, and ate her meal.

During interview on 1/28/16, at 2:56 p.m. RN-B stated she was not aware of R31 had spilled coffee onto herself, and had not seen an incident

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 _____	02/01/2016

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 323	Continued From page 102	F 323		

report regarding this to ensure an assessment had been completed to determine if any interventions were required to be put into place to prevent R31 from spilling coffee again.

During interview on 1/28/16, at 3:50 p.m. DON stated the nurse who was working when R31 spilled coffee on herself did not complete an incident report, nor was an assessment completed to ensure R31's safety when drinking coffee.

The facility policy titled Basic Responsibility: Licensed Nurse and Interdisciplinary Team dated 9/15, included, "A safety risk evaluation will be completed on admission to the facility, with quarterly review or as condition or needs change throughout the resident's stay at our facility...If the evaluation finds the resident at risk, implement appropriate interventions/precautions."

R70's admission MDS dated 9/24/15, indicated R70 had a diagnoses of bipolar disease, respiratory failure, had short term memory problems, was inattentive, and displayed disorganized thinking. The MDS further indicated R70 was independent with locomotion on and off the unit, and exhibited wandering behaviors which placed R70 at significant risk of getting to potential unsafe places.

R70's Care Area Assessment (CAA) for cognition loss/dementia dated 10/1/15, identified R70 required assistance with making safe decisions in regards to exiting the facility unattended and non-compliance with wearing his oxygen. R70's CAA for behavioral symptoms dated 10/1/15, identified R70 displayed wandering behaviors and

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 _____	02/01/2016

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 323	Continued From page 103	F 323		

had an elopement the first day at the facility. R70's CAA for falls dated 10/1/15, identified R70 had a history of acute respiratory failure with hypoxia (deficiency of available oxygen in the blood and bodily tissues), and the resident often refused to wear his oxygen, and was an elopement risk which also increased the risk for falling. The CAA identified staff were to monitor R70's whereabouts throughout the day and document if they had witnessed R70 leaving the building.

R70's physician Order Summary Report dated 1/27/16, indicated R70 had current physician orders for, "Oxygen at 2 liters [sic] per nasal cannula every shift related to OBSTRUCTIVE BRONCHITIS WITH EXACERBATION."

On 1/27/16, at 2:05 p.m. R70 was observed sitting at the edge of his bed and was trying to put his oxygen cannula in his nose. After approximately one minute, he was successful in placing the oxygen cannula back in his nose.

R70's Elopement Risk Assessment dated 9/17/15, identified R70 was at risk for elopement related to being a new admission to the facility, and displayed wandering behaviors at times. The assessment directed staff to care plan for high risk for elopement, educate staff, re-evaluate all interventions at least quarterly, and notify staff and forward information and picture to the front desk.

R70's medical record was reviewed, and the following progress notes identified:

On 9/18/15, at 10:44 p.m. [unknown] RN was called by the front desk staff and was notified R70

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 _____	02/01/2016

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 323	Continued From page 104	F 323		

was spotted walking down the road by the woods from the facility. The RN and an additional nurse began to search for the resident, and the LSW [licensed social worker] and another staff drove to pick up R70 who was located down the road by the prison, approximately 1 mile away from the facility. When R70 was asked where he was going, R70 stated, "I was going to Skylight gardens, to my apartment to get smokes and my smoke roller." The progress note further indicated R70 received a 6 centimeter (cm) long scratch on his neck, and the resident stated the scratch was from, "Walking through the bushes."

On 9/27/15, at 7:25 a.m. R70 left the facility by himself in a cab. R70 was encouraged to stay at the facility, but staff could not redirected the resident and he left the facility. Staff phoned the Assisted Living where they believed the resident had gone in the cab, and staff from the Assisted Living phoned the facility back stating R70 was sent back to the nursing home by a cab.

On 10/15/15, documented at 3:12 a.m. R70 had, "Left facility at 2130 [9:30 p.m.] to walk to gas station and buy cigarettes. At 2225 [10:25 p.m.] writer received call from off duty CNA [certified nursing assistant] that she saw him walking along the street and stopped to talk to him. He asked directions to Talahi so she called facility and asked writer to meet her at the front door to help him in. He said he needed oxygen and couldn't walk any further, assisted to w/c [wheelchair] by front door and brought him to his room, O2 [oxygen] sat [saturation] checked on the way was 89, O2 started. He had a samber sticker on the top of one of his fingers and when asked if he fell he said 'no' that he had just laid down to rest on the way back."

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 _____	02/01/2016

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 323	Continued From page 105 On 10/24/15, at 2:47 p.m., "Resident observed by staff at 10:30 [a.m.] to walk outside and walk to the side walk. Staff assisted resident with turning around and returning to facility without difficulty. He stated that he was wanting to walk to the store for cigarettes. Resident was reminded that if he leaves the building that he needs to inform staff. He stated that he understood." When interviewed on 1/27/16, at 8:20 a.m. nursing assistant (NA)-L stated R70 was able to ambulate without any difficulty, and had never wandered outside of the building that she was aware of, and was not aware of any specific interventions in place to reduce the risk of elopement for R70. During interview on 1/27/16, at 8:42 a.m. NA-A stated R70 goes outside to smoke and sits on the bench. NA-A stated R70 walks to the gas station by himself, "Every few weeks," to buy tobacco supplies, and she was never informed R70 was not able to leave the facility. R70's care plan dated 1/26/16, identified R70 was able to ambulate independently to destinations outside the facility, including the gas station. The care plan included interventions of, "Educate resident on signing out prior to leaving facility," and, "Staff will check for resident's return in 45 minutes." When interviewed on 1/26/16, at 7:35 p.m. RN-D stated R70 was supposed to wear his oxygen at all times, however, R70 was often non-compliant. RN-D stated when R70 was admitted he was "very confused, had dizziness and giddiness, and acute respiratory failure." RN-D stated when R70	F 323		

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 _____	02/01/2016

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 323	Continued From page 106	F 323		

was first admitted "he just wandered about," "asked a lot of questions," and would also try to, "go outside by himself."

During interview on 1/27/16, at 9:19 a.m. the licensed social worker (LSW)-A stated the facility protocol for residents leaving the facility was to have the resident sign out and document where they are going, what time they were leaving, and what time they were expected to return to the facility. LSW-A was unaware if R70 had been signing out of the facility to indicate when and where he was going.

During interview on 1/27/16, at 9:25 a.m. RN-A stated on 1/26/16, the prior day, she had just added new care plan interventions for R70 regarding the resident leaving the facility, after being questioned about him leaving the facility. RN-A stated R70 did not ever sign out of the facility using the Resident Release Form to her knowledge, and she stated the faciilty expected resdients to sign out of the facility when leaving. RN-A was unaware of any assessment for R70 to determine if he was safe to leave the facility, and stated she would need to speak to the DON to see if an assessment had been completed before updating R70's care plan.

An undated Resident Release Form in R70's medical record identified spacing for R70 to sign out of the facility by identifying a time he was leaving, location he would be leaving to, and an expected return time, however, R70's Resident Release Form was blank.

On 1/27/16, at 9:33 a.m. the DON, LSW-A, and RN-A were interviewed about the addition of new interventions to R70's care plan regarding his

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 _____	02/01/2016

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 323	Continued From page 107 potential elopement risk. The DON, LSW-A, and RN-A all stated R70 had not been assessed after each elopement prior to the addition of the care plan interventions on 1/26/16. DON stated she would consider R70 to be safe to ambulate to the gas station, although in October 2015, he was found by staff unable to make it back to the facility and required staff assistance to return. The facility policy titled Prevention of Elopement dated 6/2015, indicated "Elopement" was defined as, "leaving the facility or supervised environment without accompaniment or knowledge of the staff prior to their scheduled discharge." The policy also indicated assessments would be conducted upon admission/readmission, and upon significant change in condition for all residents and then quarterly for those residents identified at risk for wandering behavior or elopement. Further, the policy directed staff to prevent elopements by appropriately assessing resident risk factors, observing resident patterns, communication with family/responsible party, identifying the significance of risk factors and implementing prevention interventions.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.	F 329		3/18/16

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 _____	02/01/2016

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 329	Continued From page 108 Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure required laboratory monitoring was completed as ordered for 2 of 6 residents (R68, R12) who's medications were reviewed. In addition, the facility failed to develop guidelines on administration of medication related to alcohol use, as well as to ensure target behaviors were identified for an antianxiety medication for 1 of 1 residents (R77) who received medication when under the influence of alcohol. Findings include: R68's quarterly Minimum Data Set (MDS) dated 1/1/16, indicated the resident had a diagnoses of diabetes mellitus and received insulin injections. R68's care plan dated 11/13/15, indicated the resident had a history of alcohol abuse and type 2	F 329	F329 Rejection Reason: Were other resident charts audited to ensure labs were up to date. Anyone else who consumes ETOH who could be taking meds, system fix It is the policy of Talahi Nursing and Rehab Center that Residents medication regimen will be free from unnecessary drugs and that required and ordered lab testing is completed consistently R 77 no longer resides at facility R 68 the pharmacy consultant reviewed the medical record and made recommendations accordingly and these were forwarded to the primary MD. R 12 labs have been requested from the outside facility. Pharmacy has been contacted and request made to have Pharmacy consultant complete facility wide audit.	

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 _____	02/01/2016

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 329	Continued From page 109 diabetes mellitus, and was on diuretic therapy for ascites (accumulation of fluid in the stomach). R68's current physician orders (PO)'s dated 1/12/16, indicated the resident received metformin HCL ER (hydrocholoride extended release, used to manage diabetes) 500 mg (milligrams) two tabs daily, magnesium oxide (supplement) 400 mg one time a day, and spirolactone (a diuretic) 50 mg daily for edema. Review of R68's pharmacy consultant reports indicated on 10/08/15, a Consultation Report indicated "Please consider monitoring BMP (Basal metabolic profile, which is a blood test that measures your sugar (glucose) level, electrolyte, and fluid balance) and magnesium.. The physician responded on 11/6/15, indicating he will have this checked next week with R68's physician visit. Review of R68's medical record contained no result from the lab draw which was to be completed in November 2015. During interview on 1/28/16, at 11:39 a.m. director of nursing stated she had called Health Partners Clinic and they were supposed to complete the labs draws, however, they were not completed. DON was unaware why this had not been completed as ordered. R12's quarterly MDS dated 11/20/15, indicated R12 had diagnoses of hypertension, atrial fibrillation, and chronic kidney disease, and took a diuretic medication (used to help the body get rid of unneeded water) daily. R12's Order Summary Report dated 1/27/16, indicated R12 had current physician orders for, "Hydrochlorothiazide (a diuretic, which can deplete the body of potassium) Tablet 12.5 MG	F 329	Resident Audit completed, no other Residents found to be actively consuming ETOH Intake procedure updated to include assessing for triggers for potential self harm/harm to others to include ETOH use/abuse; this will be documented in the chart and information available to pharmacy consultant. Process for managing and processing pharmacist consultant recommendations have been updated to include 2nd check by DON or Designee The Pharmacy consultant and Pharmacy Provider have been updated on findings of the survey. The policy for use of psychotropic medication was reviewed and is current. Education to direct care nursing staff on psychotropic medication management/reduction provided Education to direct care nursing staff on psychotropic medication management policy and procedure completed Direct care staffs were educated on medication management with ETOH use The policy for use of psychotropic medication was referred to QA Ongoing Audits of psychotropic medication usage and laboratory tests as recommended by pharmacist consultant are completed with copies in the medical chart and will include review for lab recommendations. The facility alleges that it will be in substantial compliance and complete all action items by: 03/18/16	

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 _____	02/01/2016

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 329	Continued From page 110	F 329		

[milligrams] Give 12.5 mg by mouth one time a day related to UNSPECIFIED ESSENTIAL HYPERTENSION." The Order Summary Report lacked any orders for potassium supplementation.

R12's TALAHI SENIOR CAMPUS STANDING ORDERS signed and dated by the physician on 9/9/14, identified an order for, "Chem 8 [a blood test that measures the levels of several substances in the blood, including potassium] within 30 days of starting [a diuretic], then q [every] 6 mo [months]."

R12's most recent untitled laboratory report dated, 6/1/15, identified R12's last potassium level was 3.6 mEq/L (milliequivalents per liter), near the low end of the normal range of 3.5-5.0. R12's medical record lacked evidence of the potassium level being re-checked every 6 months as ordered, and had not been checked since 6/1/15, eight months prior.

During interview on 1/28/16, at 11:21 a.m. registered nurse (RN)-B stated R8 was on Hydrochlorothiazide 25 mg daily up until his recent dose reduction on 1/13/16, when the Hydrochlorothiazide dose was changed from 25 mg daily to 12.5 mg daily. In a subsequent interview on 1/29/16, at 1:21 p.m. RN-B stated R8's last Chem 8 was drawn on 6/1/15, and she was unable to locate any Chem 8 lab results from December 2015, when R8's labs should have been drawn. RN-B stated R8 was supposed to have a Chem 8 drawn every six months, however, the facility used to have a nurse that was in charge of tracking to make sure resident labs were drawn as scheduled, but, that nurses duties were redistributed so no one was tracking

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 _____	02/01/2016

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 329	Continued From page 111 to ensure routine labs were getting drawn as ordered. A policy on laboratory monitoring with medication use was requested, but none was provided. R77's annual MDS dated 12/14/15, identified R77 had medical diagnosis' which included anxiety and manic depression, had no cognitive impairment, and was independent with activities of daily living (ADLs). R77's Admission Record printed on 1/28/16, identified R77 had a, "Principal Diagnosis" of, "Alcohol Abuse with Unspecified alcohol-induced disorder," with an onset date of 8/31/15, and being present at, "Admission." The Admission Record also indicated R77 had diagnosis' including major depressive disorder and anxiety disorder, which were identified with onset dates of 9/15/14. During observation on 1/26/16, at 10:00 a.m., R77 walked up to the mobile medication cart outside the dining room and began to pace up and down the hall while waiting for the nurse to visit with him. R77 then went outside and smoked a cigarette before coming back in to speak with the nurse, however, Licensed practical nurse (LPN)-B was still conversing with another resident, so R77 stood there tapping his hand on his cane for a few minutes until the nurse was able to visit with him. R77's care plan dated 1/24/16, identified R77 had, "A behavior problem," and he was, "Noted to consume alcohol and become intoxicated." The care plan identified a goal for R77 of, "Will have fewer episodes of being intoxicated by review date," and listed interventions for R77 including, "Intervene as necessary to protect the rights and safety of others," "when [sic] resident leaves	F 329		

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 _____	02/01/2016

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 329	Continued From page 112	F 329		

facility upon return ask resident if he has alcohol in his possession," and, "Update MD as needed in regards to resident's continued alcohol consumption." The care plan did not identify interventions related to holding any specific medications if R77 had been known to be consuming alcohol.

R77's current physician orders dated 12/31/15, included, "Ativan Tablet 1 MG [milligram] (Lorazepam) [used to treat anxiety], Give 1 tablet orally every 6 hours as needed for anxiety," and, "Percocet Tablet 5-325 MG (Oxycodone-Acetaminophen) [used to treat pain/ narcotic], Give 1 tablet by mouth as needed for Pain, Give 1 tabs PO [by mouth] BID [twice daily]."

On 6/10/15, a progress note indicated R77 saw his primary physician and returned with orders to start Ativan 1 mg PRN (as needed) due to, "Possible alcohol withdrawal [sic]."

On 8/18/15, a Consultation Report from the consultant pharmacist recommended, "If the PRN [as needed] Ativan is to continue, please provide a diagnosis supporting long term use." The recommendation was returned from the physician, identifying a diagnoses of, "Anxiety-Ativan 1 mg q [every] 6 [hours] prn."

On 11/9/15, a Consultation Report from the consultant pharmacist instructed when giving R77 Ativan, nursing staff should ensure documentation in the medical record regarding target behaviors and details describing the non-pharmacological interventions that were attempted which failed to resolve R77's behavior prior to giving the Ativan, and the resulting effect of the Ativan with any observed adverse effects. The consultant pharmacist recommended, "Please remind staff of the importance of proper documentation when psychopharmacological

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 _____	02/01/2016

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 329	Continued From page 113 medications are administered." Review of R77's medical record, including progress notes, care plan, and medication administration records, lacked evidence of monitoring, documenting, or identifying target behaviors for administering the Ativan, nor did R77's medical record instruct staff to hold R77's Percocet if he was consuming alcohol. Review of R77's medication administration record from 8/2015-1/1/2016, identified R77 routinely took the PRN prescribed Percocet and Ativan. Although R77 had a primary diagnosis of alcohol abuse and continued to consume alcohol with multiple episodes of documented intoxication, the facility failed to ensure an appropriate diagnoses and target behaviors for administering Ativan, as well as to provide staff instruction on when to hold R77's Percocet. Review of R77's progress notes, included: On 9/1/15, at 2:53 p.m., R77 was noted to have signs and symptoms of intoxication and a bottle of Brandy was found in his room that was 3/4 full. At 3:00 p.m., Ativan 1 mg was administered per, "res [resident] request." On 12/18/15, R77 was administered Ativan 1 mg at 9:23 a.m., and Percocet was administered at 9:56 a.m. At 11:37 a.m., R77 was found intoxicated in his room. When interviewed on 1/28/16, at 10:00 a.m., registered nurse (RN)-B stated R77 had his medications held on several occasions due to being too intoxicated to safely take them, however, the facility did not have specific guidelines on when to hold R77 medications. During interview on 1/28/16, at 1:35 p.m. DON stated there were no specific interventions regarding when to hold R77's medication if he had been drinking alcohol, however, nursing staff	F 329		

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 _____	02/01/2016

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 329	Continued From page 114 "knows" they should be assessing R77 prior to administering his medication, and if they suspect he was drinking, they can use their own judgment to determine what further interventions should be provided, including if his medications can be safely administered. During interview on 1/28/16, at 2:15 p.m. consultant pharmacist stated she was aware R77 was drinking alcohol and becoming intoxicated, however, she had never made specific recommendations in relation to his medication and alcohol consumption as she left that decision up to the physician. The consultant pharmacist stated it is not safe to consume alcohol and take any narcotic medication together. A facility policy regarding holding resident medication and/ or assessing resident condition to administer medication was requested but not provided.	F 329		
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing	F 353		3/11/16

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 _____	02/01/2016

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 353	Continued From page 115 personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide adequate staffing to ensure residents received the required assistance with bathing for 7 of 8 residents (R80, R84, R59, R81, R76, R86, R63) reviewed for activities of daily living, 2 of 3 residents (R5, R69) reviewed for choices with bathing, and 1 of 1 residents (R39) reviewed for pressure ulcer care and incontinence. In addition, for 6 of 6 residents (R23, R5, R69, R25, R8, and R51), 3 of 5 family members (FM-K, FM-J, FM-P), and for 5 of 5 staff members (NA-A, NA-O, RN-A, NA-C, and RN-B) who expressed care was not being completed as required for residents due to the lack of sufficient staffing in the facility. This had the potential to effect all 71 residents who resided in the facility. Findings include: ASSESSED RESIDENT NEEDS NOT BEING MET: - Refer to F242 as the facility failed to honor bathing preferences for 2 of 3 residents (R5 and R69) reviewed for bathing choices. - Refer to F311 as the facility failed to ensure assistance was provided for 1 of 3 residents	F 353	F353 It is the policy of Talahi Nursing and Rehab Center that there is adequate staffing on the floor to provide nursing and related services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident per their individual plans of care. Orientation was revised for on-boarding of staff to include call light management and response time. Auditing of staffing patterns r/t high times of needs completed to determine more appropriate staffing patterns. Meetings were held with staff to determine the most appropriate allocation of staff hours. Review of call light response times to determine trends or patterns, ie: increased call light response time in correlation with decreased staffing. Review of call light system to determine equipment needs to ensure a more timely response time completed. Call light policy/procedure reviewed and updated to be current Information in regards to staffing procedures was communicated at resident council.	

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 _____	02/01/2016

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 353	Continued From page 116 (R39), who required supervision and staff assistance with eating. In addition, the facility failed to ensure bathing was completed for 5 of 6 residents (R80, R84, R59, R76, and R86) who required staff assistance with bathing. - Refer to F312 as the facility failed to ensure timely assistance with toileting, and assistance with oral care and shaving for 1 of 8 residents (R39) reviewed for activity of daily living assistance. The facility also failed to ensure bathing was completed for 1 of 7 residents (R81) reviewed for bathing. - Refer to F314 as the facility failed to ensure timely repositioning, and a comprehensive assessment was completed for 2 of 2 residents (R37 and R39) at risk for developing pressure ulcers. RESIDENT / FAMILY COMPLAINTS ABOUT LACK OF STAFFING: R23's admission Minimum Data Set (MDS) dated 12/8/15, identified R23 had moderate cognitive impairment, and required at least limited assistance with her activities of daily living (ADLs). During interview on 1/26/16, at 1:23 p.m. R23 and family member (FM)- K both stated they felt the facility did not have enough staff to care for the residents. FM-K stated the nursing assistant (NA) staff will answer R23' call light and tell her, "Just a minute," and then not return for extended periods of time. FM-K stated recently R23 had to use the restroom and ended up waiting a long time to get assistance adding, "She [R23] waited	F 353	Staffing information was shared at staff meeting. Review of call light response time policy at staff meeting Education provided to direct care staff regarding best practice for toileting, bathing and feeding assistance to maintain resident□s safety and wellbeing Call light response time referred to QA Audits of staff and resident interviews will be conducted weekly in regards to staffing and meeting resident needs. Weekly call light response time report audit/review to be completed by IDT The facility alleges that it will be in substantial compliance and complete all action items by: 03/11/16	

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 _____	02/01/2016

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 353	Continued From page 117	F 353		

longer that I could." Further, R23 stated she had episodes of urinary incontinence before because of having to wait long periods of time for assistance to use the restroom.

R23's Device Activity Report (call light response times) from 1/15/16, to 1/29/16, identified the following call light response times:
- 1/15/16 at 8:40 a.m. - call light on 23 minutes.
- 1/19/16 at 8:37 a.m.- call light on 38 minutes.
- 1/23/16 at 12:26 p.m.- call light on 22 minutes.
- 1/24/16 at 3:28 p.m.- call light on for 30 minutes.
- 1/28/16 at 11:37 p.m.- call light on for 61 minutes.

R5's quarterly MDS dated 12/28/15, identified R5 had no memory concerns, and required extensive assistance with ADLs.

During interview on 1/25/16, at 11:06 a.m. R5 stated she did not feel the facility was adequately staffed and often had to wait 30 minutes or more to have her call light answered. The past Saturday (1/23/16), R5 stated her call light was on for almost 30 minutes on two separate occasions in the morning and she had to scream for help until an aide responded to finally help her. R5 stated she had missed bathing, and not had her bath in the morning as desired because the bath aide gets pulled to work on the floor due to the short staffing in the facility.

R69's quarterly MDS dated 10/14/15, identified R69 had intact cognition, and required extensive assistance to complete ADLs.

During interview on 1/25/16, at 3:08 p.m. R69 stated he has to, "Wait and wait," for his call light to be answered and stated at times it is up to 45

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 _____	02/01/2016

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 353	Continued From page 118	F 353		

minutes before the call light was answered. R69 stated he was not always able to hold his bladder long enough, and had incontinence episodes because of waiting for staff to answer his light. R69 also stated he does not get his desired bathing every week because they do not have enough staff to assist him.

R69's Device Activity Report from 1/15/16, to 1/29/16, identified the following call light response times:
- 1/16/16 at 12:38 p.m.- call light was on for 39 minutes.
- 1/19/16 at 9:15 p.m.- call light was on for 37 minutes.
- 1/23/16 at 1:13 p.m.- call light was on for 40 minutes.

R25's quarterly MDS dated 11/9/15, identified R25 had intact cognition.

During interview on 1/25/16, at 1:23 p.m. R25 stated she often had to wait extended periods of time in the morning to receive assistance with getting dressed. R25 stated she will turn her call light on and at times had waited for nearly 90 minutes to receive help.

R25's Device Activity Report from 1/15/16 to 1/29/16, identified the following call light response times:
- 1/15/16 at 4:13 p.m. - call light on for 52 minutes.
- 1/16/15 at 7:26 a.m. - call light on for 33 minutes.
- 1/25/16 at 7:51 a.m. - call light on for 79 minutes.

R8's quarterly MDS dated 11/2/15, identified R8

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 _____	02/01/2016

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 353	Continued From page 119	F 353		

had intact cognition, and required total care from staff for his ADLs.

During interview on 1/25/16, at 3:42 p.m. R8 stated he often had to wait for long periods to receive help after using his call light to receive assistance from staff for ADL's.

R51's quarterly MDS dated 11/27/15, identified R51 had intact cognition, and required extensive assistance with ADLs.

During interview on 1/26/16, at 12:43 p.m. R51 stated the facility was short staffed and needed more help. R51 stated the night times were the worst for short staffing, and would sometimes have to wait up to 30 minutes to get assistance using his urinal and stated, "I have wet my bed at night because the staff didn't answer my call light fast enough."

R51's Device Activity Report from 1/15/16 to 1/29/16, identified the following call light response times:
- 1/18/16, at 5:20 a.m.- call light was on for 42 minutes.
- 1/20/16 at 6:36 a.m.- call light was on for 32 minutes.
- 1/23/16 at 6:35 a.m.- call light was on for 31 minutes.
- 1/23/16 at 12:43 p.m.- call light was on for 67 minutes.
- 1/24/16 at 5:27 a.m. - call light was on for 26 minutes.
- 1/25/16 at 11:44 a.m. - call light was on for 30 minutes.
- 1/28/16 at 10:29 a.m. - call light was on for 32 minutes.
- 1/28/16 at 11:54 a.m.- call light was on for 38

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 _____	02/01/2016

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 353	Continued From page 120	F 353		

minutes.
- 1/29/16 at 6:37 a.m.- call light was on for 65 minutes.

During interview on 1/26/16, at 2:43 p.m. FM-J stated she thought the facility was understaffed at times, and when coming to visit R39 in the past, no staff would be available to assist R39 with eating as she required.

During interview on 1/27/16, at 2:14 p.m. FM-P stated the facility, particularly the locked unit, was understaffed and family had to hire out additional help as a result. R76 enjoyed talking, and staff at the facility did not have time to do that with him because of the lack of staff. FM-P stated the facility was very well staffed this week during survey, however, this was not the typical staffing pattern.

STAFF CONCERNS WITH LACK OF STAFF:

When interviewed on 1/26/16, at 6:30 p.m. NA-O stated she was not always able to get her work completed because of the lack of staff at the facility, and during meal times it was hard to answer call lights promptly and residents had to wait for a long time for help. NA-O stated there used to be a float staff that would help residents with smoking, bathing, and getting their ADLs completed, but it had been decided by management the float staff was no longer needed.

During interview on 1/27/16, at 7:05 a.m. NA-A stated she has been pulled to the floor because of short staffing, so bathing was not always being completed for residents. NA-A stated staffing at

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 _____	02/01/2016

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 353	Continued From page 121	F 353		

the facility was never consistent, and the schedule, "Always [has] some open spots." NA-A stated the facility used to have a float position which helped a lot in the mornings, but for the past few weeks, there had been no float person. NA-A was unaware why the float position was no longer being used.

During interview on 1/27/16, at 7:31 a.m. registered nurse (RN)-A stated residents aren't always provided their desired bathing because of the short staffing situation at the facility. If there was a call-in, or lack of staff on the floor, the bath aide was taken off the bath duty to assist on the floor with resident cares, and a replacement to provide resident baths was not always possible. RN-A stated the facility used to have a float position which would go between all the units and help residents, but there hadn't been one recently for the past tow or three weeks, and resident call light response times were becoming longer as a result.

When interviewed on 1/28/16, at 8:09 a.m. NA- C stated there were typically three NA's on the locked unit, plus a bath aide, however, lately resident bathing was not being completed because the bath aides were being pulled to the floor because of short staffing in the facility.

During interview on 1/28/16, at 8:49 a.m. RN-B stated the bath aide was pulled to help out on the floor when there is a call-in, and bathing was not being completed consistently as a result. RN-B stated every administration feels differently about staffing, and the facility used to have a float position which helped ensure care was completed, however, the float was no longer being used.

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 _____	02/01/2016

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 353	Continued From page 122 When interviewed on 1/28/16, at 5:07 p.m. the director of nursing (DON) stated the float position was, "Pulled from corporate," but she was unsure why. The facility typically staffed according to acuity, and had two NA staff on the North unit, two NA staff on the West unit, and three NA staff on the East (locked) unit. The DON stated staff will, "Always say their short, no matter what you give them," and added some staff have come to her and told her their concerns about the lack of staffing. The DON stated she was aware of the lack of consistent resident bathing, "[There] are concerns they [baths] are not getting done," as the bath aide was being pulled to the floor when there is short staffing and/or call-ins. DON stated the facility was trying to hire new staff, but had not discussed changing around duties or hours to make better use of the staff they have.	F 353		
F 367 SS=D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure staff were trained to thicken liquids to the appropriate consistency to reduce the risk of aspiration for 3 of 3 residents (R76, R7, and R59) reviewed with thickened liquids. Findings include: R76's Admission Record, dated 8/25/14, identified diagnoses, including a history of	F 367	F367 It is the policy of Talahi Nursing and Rehab Center that all staff have adequate training, knowledge and understanding of the preparation and use of thickened liquids. Residents R7, R 76 and R 59 were re assessed by speech therapy for appropriate thickness of liquids and care plans reviewed.	3/4/16

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 _____	02/01/2016

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 367	Continued From page 123 traumatic brain injury, dementia, and dysphagia (difficulty with swallowing). R76's quarterly Minimum Data Set (MDS), dated 1/7/16, identified R76 had long and short-term memory loss, required a mechanically altered diet, and was independent with eating after set up. R76's physician Order Summary Report dated 12/31/15, included dietary orders for, "Regular diet, Pureed texture, Honey consistency, pureed with ground meat, honey thick liquids, free water protocol." R76's care plan dated 1/14/16, indicated R76 had a swallowing problem related to difficulty with thin liquids, and had an order for honey thickened liquids and pureed diet with ground meat. Interventions included, "All staff to be informed of resident's special dietary and safety needs." During observation on 1/26/16, at 12:33 p.m. R76 was given a plastic cup with coffee. When stirred, the coffee was still thin, and did not appear to be of honey consistency as ordered. R76 stated, "That's how I like it." R76 was then given a plastic glass with chocolate milk and a small plastic glass with orange juice and both appeared to be of honey consistency. During interview on 1/26/16, at 12:37 p.m. trained medication assistant (TMA)-A stated she thickened coffee for the residents who required thickened consistency, and displayed a small plastic, unmarked, storage container from the medication cart that held white powder, and stated she mixed a teaspoon into R76's coffee. TMA-A stated she thought the consistency	F 367	Thicken fluid orders have been added to the EMAR The facility will buy pre thickened fluids for distribution The policy and procedure for thickened fluids has been reviewed and is current. Direct care staff orientation schedule reviewed and updated to include thickened liquids p/p Written instructions on how to thicken liquids will be made available for staff to refer to on all nurses□ stations Education was provided to culinary, activity and clinical staff responsible for serving liquids on how to thicken fluids. Preparation and use of thickened liquids procedure referred to QA 5 Audits per week x 6 weeks will be completed to assure residents are receiving the correct diet and fluid consistency. The facility alleges that it will be in substantial compliance and complete all action items by: 03/04/16	

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 _____	02/01/2016

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 367	Continued From page 124	F 367		

seemed appropriate.

During an interview on 1/27/15, at 2:14 p.m. family member (FM)-P stated she needs to remind staff all the time about thickening R76's liquids. FM-P stated the staff didn't know how much of the thickener they should mix into the beverages for the correct consistency, and there are times when it doesn't look thick enough.

During an interview on 1/27/2016, at 3:04 p.m. R76's companion stated staff will set coffee down in front of R76 that is not thickened, or is not the appropriate consistency.

R7's Admission Record dated 4/27/15, identified diagnoses including dementia, chronic obstructive pulmonary disease, and dysphagia.

R7's annual MDS, dated 1/2/16, included R7 had severe cognitive impairment, required a mechanically altered and therapeutic diet, and required limited assistance with eating.

R7's Order Summary Report dated 12/31/15, included dietary orders for, "NAS (No Added Salt) diet, Regular texture, Nectar consistency."

R7's care plan dated 1/9/16, indicated R7 had a swallowing problem related to difficulty with thin liquids and needed nectar thick liquids. Interventions included, "All staff to be informed of resident's special dietary and safety needs."

During observation on 1/26/16, at 6:20 p.m., R7 was sitting in the Rosewood dining room, waiting for her meal. R7 had a loose cough and used a tissue to cover her mouth. R7 had a plastic cup with coffee in which had the consistency of

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 _____	02/01/2016

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 367	Continued From page 125 pudding. NA-F verified that she mixed the thickener into R7's coffee and it seemed, "Too thick." R59's Admission Record, dated 6/22/15, identified diagnoses including disorientation, chronic obstructive pulmonary disease, respiratory disorder, and gastroespophageal reflux. R59's significant change MDS dated 1/15/16, included R59 had moderate cognitive impairment, required mechanically altered and therapeutic diet, and required supervision with eating. R59's physician Order Summary Report dated 12/22/15, included dietary orders for, "Modified Diabetic diet, Regular texture, Nectar consistency." R59's care plan dated 1/14/16, indicated R59 had a swallowing problem related to difficulty with thin liquids related to recurrent aspiration pneumonia. Interventions included, "All staff to be informed of resident's special dietary and safety needs." During observation on 1/26/16, at 12:34 p.m., R59 had a plastic cup with coffee in front of him. R59 used a spoon to mix in sugar and powdered creamer. The consistency was slightly thickened. During interview on 1/26/16, at 12:37 p.m. trained medication assistant (TMA)-A stated she thickened coffee for the residents who required thickened consistency, and displayed a small plastic, unmarked, storage container from the medication cart and stated she mixed 1/2 teaspoon of the thickener into R59's coffee.	F 367		

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 _____	02/01/2016

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 367	Continued From page 126 TMA-A stated she thought the consistency of R59's coffee seemed appropriate. During interview on 1/26/16, at 12:52 p.m. cook (C)-A and dietary aide (DA)-B stated the facility received cartons of nectar and honey thickened juice, however, staff were responsible for thickening coffee for residents requiring thickened liquids. C-A stated staff will, "Put a little bit in and stir it until it gets to the right consistency." DA-B stated she thought nectar and honey consistency were, "all the same." During interview on 1/26/16, at 1:09 p.m. dietary manager stated, "In a six ounce coffee cup, I would start with three teaspoons and let it sit to see how much it thickens up. If it's to be honey thick, I'd start with four teaspoons and go up from there." During interview on 1/26/16, at 1:26 p.m., nursing assistant (NA)-F stated R76, R7, and R59 all get the same amount of thickener in their coffee. NA-F stated she had not been specifically trained at the facility regarding mixing thickened liquids to the correct consistency, however, she had been trained at a previous place of employment. NA-F stated she wasn't sure if the thickened powder was to be used for nectar or honey consistency. During interview on 1/27/16, at 8:52 a.m. NA-Q stated she usually mixed in the same amount of thickener for all residents, regardless if the resident was to receive nectar or honey consistency. NA-Q stated R76 was pretty vocal and would let the staff know if his coffee was too thick or too thin. During interview on 1/28/16, at 9:16 a.m.	F 367		

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 _____	02/01/2016

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 367	Continued From page 127 registered nurse (RN)-B stated the facility didn't have a specific training for staff to thicken liquids, however, they just learned from each other. A review of the facility's policy, Meals-Preparing and Serving, dated 12/31/10, included, "Nursing personnel check food for appropriate content, texture, and temperature." The policy lacked information regarding thickened liquids.	F 367		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medications	F 425	F425 Rejection Reason: Were other	3/11/16

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 _____	02/01/2016

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 425	Continued From page 128 were labeled in accordance with current physician orders to reduce potential administration errors for 2 of 7 residents (R92, R8) observed to receive medication and for 1 of 1 residents (R76) who no longer required a gastrostomy tube to receive medications. Findings include: During observation of medication administration on 1/25/16, at 12:27 p.m. licensed practical nurse (LPN)-B prepared R92's medications at a mobile cart outside the dining room. LPN-B provided a bottle of medication to the surveyor for review which identified R92 was to receive Fish Oil 1000 mg (milligrams) 1 capsule by mouth twice a day. LPN-B finished preparing the remainder of R92's medications and administered them. R92's Order Summary Report dated 1/5/16, identified an order for, "Fish Oil Capsule ... Give 1000 mg by mouth one time a day..." When interviewed about the discrepancy on 1/26/16, at 7:35 p.m. LPN-B stated R92 was only receiving it once daily, and the medication label was incorrect. LPN-B stated she had observed some of the trained medication aide (TMA) staff to pass medications using only the label, and an incorrect medication label could result in an error. During observation of medication administration on 1/25/16, at 12:37 p.m. LPN-B prepared R8's medications at a mobile cart. LPN-B provided the surveyor a bottle of Hypromellose 0.3% ophthalmic (eye) drops to be administered to R8 which identified directions of, "Instill 1 drop in each eye at bedtime for dry eyes." LPN-B then administered the eye drops to R8.	F 425	resident□s meds reviewed to ensure correct labeling It is the policy of Talahi Nursing and Rehab Center that the residents receive safe and accurate medication administration. The medication for R 8 and R 92 is no longer here and a change order sticker placed on the containers. The orders for R76 were updated to include the right route. In house random audits of medication labels vs physician orders initiated. Request to Pharmacy provider to provide consultant to complete facility wide medication audits. The policy and procedure for medication administration and management of order changes has been reviewed and is current Procedure to process medication order changes reviewed and is current Education was completed on the 6 rights on medication pass for staff responsible for administration of medication. Medication administration policy and procedure referred to QA 3 Audits per week x 6 weeks of medication administration including the 6 rights and medication order changes will be conducted The facility alleges that it will be in substantial compliance and complete all action items by: 03/11/16	

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 _____	02/01/2016

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 425	Continued From page 129 R8's Order Summary Report dated 9/18/15, identified an order for, "Hypromellose Solution 0.3 % [percent] Instill 1 drop in both eyes four times a day..." When interviewed on 1/25/16, at 12:51 p.m. LPN-B stated R8 was currently receiving the eye drops four times a day, and had been getting them that often for at least the past eight months. LPN-B stated the eye drop label was not correct, and she would notify pharmacy to obtain a new one. LPN-B stated the medication label should match the physician order to, "Avoid medication errors." During interview on 1/29/16, at 8:07 a.m. the director of nursing (DON) stated nursing staff should be updating the pharmacy with order changes, and having the label replaced with the new and current physician orders. R76's Admission Record dated 8/25/14, identified diagnoses which included a history of dysphagia (difficulty with swallowing). During observation of the medication cart on the Rosewood wing, on 1/28/16, at 9:16 p.m., R76 had medications with the following labels: Vitamin B1 100mg (milligrams) via G (gastrostomy) tube daily. Gabapentin 100 mg one cap via G tube tid (three times daily). Klor Con 20 meq (milliequivalents) one tab via G tube twice daily. Folic Acid 1 mg one tab via G tube daily. R76's physician orders, dated 12/31/16, included:	F 425		

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 _____	02/01/2016

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 425	Continued From page 130 Thiamine HCl (Vitamin B1) tablet 100 mg, Give 1 tablet by mouth one time a day. Neurontin Capsule 100 mg (Gabapentin), Give 100 mg by mouth three times a day. Potassium Chloride ER (Klor Con) Tablet 20 meq, Give 20 meq by mouth two times a day. Folic Acid tablet 1 mg, Give 1 tablet by mouth one time a day. During interview on 1/28/16, at 9:08 a.m. registered nurse (RN)-B stated R76 had a gastrostomy tube until 9/2/15. RN-B stated the pharmacy was notified R76 no longer had a gastrostomy tube, and the labels on the medication should reflect R76 takes the medications, "By mouth." Review R76's Consultation Report from the consulting pharmacist dated 9/8/15, included, "[R76's] feeding tube was removed, but he continues to be administered several liquid medications...and the label directions for all medications still state per g-tube...Please consider changing liquid dosage preparations to solid oral dosage forms at the equivalent dosage and notify pharmacy that he is now taking medications orally." A Consultation Report dated 11/9/15, included, "Also, notify/fax pharmacy that the orders/labels should read "PO [by mouth]" not via G-tube." A handwritten note indicated the Consultation Report was faxed to the pharmacy on 12/4/15, however, the labels were not corrected. During interview on 1/29/16, at 2:08 p.m. consultant pharmacist stated the facility should have notified the pharmacy if the labels were incorrect.	F 425		

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 _____	02/01/2016

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 425	Continued From page 131 During a follow up interview on 1/29/16, at 2:49 p.m. RN-B stated she didn't know if anyone had called the pharmacy about R76's medication labels being incorrect, however, she would have expected this should have been completed. During interview on 1/29/16, at 2:55 p.m. director of nursing (DON) stated all medication labels should match the physician order. A policy regarding medication labeling was requested but not provided.	F 425		
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the consulting pharmacist failed to ensure lab monitoring was completed for 2 of 5 residents (R68 and R12) reviewed for unnecessary medications. In addition, the consulting pharmacist failed to provide recommendations to the facility regarding administration of medication related to alcohol use, as well as to ensure target behaviors were consistently being identified for an	F 428	F428 It is the policy of Talahi Nursing and Rehab Center that all residents will have a medication review completed by a consulting pharmacist, recommended labs will be addressed with the attending MD and psychotropic medication management program will be followed. The consulting pharmacist was informed	3/11/16

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 _____	02/01/2016

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 428	Continued From page 132 antianxiety medication for 1 of 1 residents (R77) who received medication when under the influence of alcohol. Findings include: R68's quarterly Minimum Data Set (MDS) dated 1/1/16, indicated the resident had a diagnoses of diabetes mellitus and received insulin injections. R68's care plan dated 11/13/15, indicated the resident had a history of alcohol abuse and type 2 diabetes mellitus, and was on diuretic therapy for ascites (accumulation of fluid in the stomach). R68's current physician orders (PO)'s dated 1/12/16, indicated the resident received metformin HCL ER (hydrocholoride extended release, used to manage diabetes) 500 mg (milligrams) two tabs daily, magnesium oxide (supplement) 400 mg one time a day, and spirolactone (a diuretic) 50 mg daily for edema. Review of R68's pharmacy consultant reports indicated on 10/08/15, a Consultation Report indicated "Please consider monitoring BMP (Basal metabolic profile, which is a blood test that measures your sugar (glucose) level, electrolyte, and fluid balance) and magnesium.. The physician responded on 11/6/15, indicating he will have this checked next week with R68's physician visit. Review of R68's medical record contained no result from the lab draw which was to be completed in November 2015. During interview on 1/28/16, at 11:39 a.m. director of nursing stated she had called Health Partners Clinic and they were supposed to complete the	F 428	of the irregularities and completed a whole house audit. R 77 no longer resides at facility R 68 the pharmacy consultant reviewed the medical record and made lab recommendations accordingly and these were forwarded to the primary MD. R 12 - labs have been requested from the outside facility. The policy for consulting pharmacist has been reviewed and is current. Psychotropic medication usage/monitoring/management and reduction P&P reviewed with all direct care staff Psychotropic medication usage/monitoring/management and reduction P&P referred to QA 2 Audits per week x 6 weeks of psychotropic medication usage/monitoring/management and reduction to be completed. 2 Audits per week x 6 weeks of compliance with lab monitoring recommendations, assuring labs are competed with copies in the medical record will be completed. The facility alleges that it will be in substantial compliance and complete all action items by: 03/11/16	

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 _____	02/01/2016

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 428	Continued From page 133	F 428		

labs draws, however, they were not completed. DON was unaware why this had not been completed as ordered.
During interview 1/29/16, at 3:15 p.m. the consultant pharmacist (CP) stated she had made the recommendation on 10/08/15, that R68 should have blood work completed, and she would have expected the facility to complete the labs. The CP stated without seeing R68's medical record, she could not say why she had not noted the labs were missed and followed up with the facility and/ or the physician.

R12's quarterly MDS dated 11/20/15, indicated R12 had diagnoses of hypertension, atrial fibrillation, and chronic kidney disease, and took a diuretic medication (used to help the body get rid of unneeded water) daily.

R12's Order Summary Report dated 1/27/16, indicated R12 had current physician orders for, "Hydrochlorothiazide (a diuretic, which can deplete the body of potassium) Tablet 12.5 MG [milligrams] Give 12.5 mg by mouth one time a day related to UNSPECIFIED ESSENTIAL HYPERTENSION." The Order Summary Report lacked any orders for potassium supplementation.

R12's TALAHI SENIOR CAMPUS STANDING ORDERS signed and dated by the physician on 9/9/14, identified an order for, "Chem 8 [a blood test that measures the levels of several substances in the blood, including potassium] within 30 days of starting [a diuretic], then q [every] 6 mo [months]."

R12's most recent untitled laboratory report dated, 6/1/15, identified R12's last potassium

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 _____	02/01/2016

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 428	Continued From page 134	F 428		

level was 3.6 mEq/L (milliequivalents per liter), near the low end of the normal range of 3.5-5.0. R12's medical record lacked evidence of the potassium level being re-checked every 6 months as ordered, and had not been checked since 6/1/15, eight months prior.

During interview on 1/28/16, at 11:21 a.m. registered nurse (RN)-B stated R8 was on Hydrochlorothiazide 25 mg daily up until his recent dose reduction on 1/13/16, when the Hydrochlorothiazide dose was changed from 25 mg daily to 12.5 mg daily. In a subsequent interview on 1/29/16, at 1:21 p.m. RN-B stated R8's last Chem 8 was drawn on 6/1/15, and she was unable to locate any Chem 8 lab results from December 2015, when R8's labs should have been drawn. RN-B stated R8 was supposed to have a Chem 8 drawn every six months, however, the facility used to have a nurse that was in charge of tracking to make sure resident labs were drawn as scheduled, but, that nurses duties were redistributed so no one was tracking to ensure routine labs were getting drawn as ordered.

R12's Consultant Pharmacist Drug Regimen Review, dated 6/18/15 to 1/20/16, did not address the need for R12's need of laboratory monitoring with the ongoing use of Hydrochlorothiazide.

When interviewed on 1/29/16, at 3:25 p.m. consulting pharmacist (CP) stated R12 was on Hydrochlorothiazide 12.5 mg daily, and should have had a Chem 8 drawn in December 2015.

R77's annual Minimum Data Set (MDS) dated 12/14/15, identified R77 had medical diagnosis' which included anxiety and manic depression,

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 _____	02/01/2016

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 428	Continued From page 135	F 428		

had no cognitive impairment, and was independent with activities of daily living (ADLs).
R77's Admission Record printed on 1/28/16, identified R77 had a, "Principal Diagnosis" of, "Alcohol Abuse with Unspecified alcohol-induced disorder," with an onset date of 8/31/15, and being present at, "Admission." The Admission Record also indicated R77 had diagnosis' including major depressive disorder and anxiety disorder, which were identified with onset dates of 9/15/14.
During observation on 1/26/16, at 10:00 a.m., R77 walked up to the mobile medication cart outside the dining room and began to pace up and down the hall while waiting for the nurse to visit with him. R77 then went outside and smoked a cigarette before coming back in to speak with the nurse, however, Licensed practical nurse (LPN)-B was still conversing with another resident, so R77 stood there tapping his hand on his cane for a few minutes until the nurse was able to visit with him.
R77's care plan dated 1/24/16, identified R77 had, "A behavior problem," and he was, "Noted to consume alcohol and become intoxicated." The care plan identified a goal for R77 of, "Will have fewer episodes of being intoxicated by review date," and listed interventions for R77 including, "Intervene as necessary to protect the rights and safety of others," "when [sic] resident leaves facility upon return ask resident if he has alcohol in his possession," and, "Update MD as needed in regards to resident's continued alcohol consumption." The care plan did not identify interventions related to holding any specific medications if R77 had been known to be consuming alcohol.
R77's current physician orders dated 12/31/15, included, "Ativan Tablet 1 MG [milligram]

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 _____	02/01/2016

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 428	Continued From page 136	F 428		

(Lorazepam) [used to treat anxiety], Give 1 tablet orally every 6 hours as needed for anxiety," and, "Percocet Tablet 5-325 MG (Oxycodone-Acetaminophen) [used to treat pain/ narcotic], Give 1 tablet by mouth as needed for Pain, Give 1 tabs PO [by mouth] BID [twice daily]."

On 6/10/15, a progress note indicated R77 saw his primary physician and returned with orders to start Ativan 1 mg PRN (as needed) due to, "Possible alcohol withdrawal [sic]."

On 8/18/15, a Consultation Report from the consultant pharmacist recommended, "If the PRN [as needed] Ativan is to continue, please provide a diagnosis supporting long term use." The recommendation was returned from the physician, identifying a diagnoses of, "Anxiety-Ativan 1 mg q [every] 6 [hours] prn."

On 11/9/15, a Consultation Report from the consultant pharmacist instructed when giving R77 Ativan, nursing staff should ensure documentation in the medical record regarding target behaviors and details describing the non-pharmacological interventions that were attempted which failed to resolve R77's behavior prior to giving the Ativan, and the resulting effect of the Ativan with any observed adverse effects. The consultant pharmacist recommended, "Please remind staff of the importance of proper documentation when psychopharmacological medications are administered."

Review of R77's medical record, including progress notes, care plan, and medication administration records, lacked evidence of monitoring, documenting, or identifying target behaviors for administering the Ativan, nor did R77's medical record instruct staff to hold R77's Percocet if he was consuming alcohol.

Review of R77's medication administration record

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 _____	02/01/2016

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 428	Continued From page 137 from 8/2015-1/1/2016, identified R77 routinely took the PRN prescribed Percocet and Ativan. Although R77 had a primary diagnosis of alcohol abuse and continued to consume alcohol with multiple episodes of documented intoxication, the facility failed to ensure an appropriate diagnoses and target behaviors for administering Ativan, as well as to provide staff instruction on when to hold R77's Percocet. Review of R77's progress notes, included: On 9/1/15, at 2:53 p.m., R77 was noted to have signs and symptoms of intoxication and a bottle of Brandy was found in his room that was 3/4 full. At 3:00 p.m., Ativan 1 mg was administered per, "res [resident] request." On 12/18/15, R77 was administered Ativan 1 mg at 9:23 a.m., and Percocet was administered at 9:56 a.m. At 11:37 a.m., R77 was found intoxicated in his room. When interviewed on 1/28/16, at 10:00 a.m., registered nurse (RN)-B stated R77 had his medications held on several occasions due to being too intoxicated to safely take them, however, the facility did not have specific guidelines on when to hold R77 medications. During interview on 1/28/16, at 1:35 p.m. the director of nursing (DON) stated there were no specific interventions regarding when to hold R77's medication if he had been drinking alcohol, however, nursing staff "knows" they should be assessing R77 prior to administering his medication, and if they suspect he was drinking, they can use their own judgment to determine what further interventions should be provided, including if his medications can be safely administered. During interview on 1/28/16, at 2:15 p.m.	F 428		

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 _____	02/01/2016

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 428	Continued From page 138 consultant pharmacist stated she was aware R77 was drinking alcohol and becoming intoxicated, however, she had never made specific recommendations in relation to his medication and alcohol consumption as she left that decision up to the physician. The consultant pharmacist stated it is not safe to consume alcohol and take any narcotic medication together. A facility policy titled PHARMACY ROLE revised 10/2014, indicated, "The consultant pharmacist shall conduct on a monthly basis a review of each resident's drug regimen. The review will include screening for drug interactions, adverse reactions, appropriate dose and overall safe, effective and appropriate therapy."	F 428		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to	F 441		2/29/16

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 _____	02/01/2016

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 441	Continued From page 139 prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement an infection control program which included surveillance, investigation of infections, and analysis of collected data to determine interventions to prevent the spread of infection. This had the potential to affect all 71 residents who resided in the facility. In addition the facility failed to wear gloves and complete hand hygiene for 1 of 1 residents (R57) observed to receive insulin, and for 2 of 4 residents (R39, R53) whose morning cares were observed. Findings include: During review of the facility's infection control program dated 6/1/15, to 12/31/15, with the infection control nurse (RN)-C and director of nursing (DON) on 1/27/16, at 2:06 p.m. the	F 441	F441 It is the policy of Talahi Nursing and Rehab Center that they have established and will maintain an infection control program that will ensure the facility is providing a safe, sanitary and comfortable environment, decrease risk of disease and infection transmission through follow up investigation and provides staff education to promote compliance with infection control best practices. The infection control policy, glove and hand washing policy has been reviewed and is current The infection control report has been updated. A tracking form for infections have been placed at each nursing station Education was completed on hand	

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 _____	02/01/2016

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 441	Continued From page 140 following information was identified: The facilities' infection control program consisted of identifying the residents name, antibiotic and wing location. However, the program failed to consistently identify the affected resident's room number, identified start of the infection date, date in which the infection resolved, symptoms displayed, analysis, or any tracking and trending of infections. Review of the infection flowsheet labeled October 2015, identified there were three urinary tract infections (UTI) all located on the west wing, along with one sinus congestion. The infection flowsheet identified what antibiotic the resident was on, but lacked to identify the on-set date, symptoms, room number/location, culture, where the infection was acquired, and if it was resolved. Further, there was no evidence the facility investigated to determine if the three UTI's identified could be related, and if education to staff or training was required as a result. Review of the infection program for the month of November 2015, indicated three UTI's, one cellulitis to lower extremity, one respiratory infection, one wound, one C-Diff (Clostridium difficile colitis, an inflammation of the large intestine resulting from infection), and one sinus infection. The program identified what antibiotic the resident(s) were on, but lacked to identify the on-set date, symptoms, room number/location, culture, where the infection was acquired, and if it was resolved. Review of the infection program for the month of December 2015, indicated the facility had one cellulitis infection, two pneumonia infections, and one new UTI. The program identified what	F 441	washing/hand sanitizing and use of gloves with all direct care staff. Education on tracking and monitoring infections was completed with direct care staff. Education on the correct handling of linens (clean and dirty) completed with all direct care staff. 5 weekly Audits x 6 weeks on hand washing and the use of gloves will be completed. Weekly Audits x 6 weeks on the completion of infection tracking logs. Infection monitoring/tracking and prevention audit monthly with QA The facility alleges that it will be in substantial compliance and complete all action items by: 02/29/16	

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 _____	02/01/2016

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 441	Continued From page 141 antibiotic the resident(s) were on, but failed to identify the on-set date, symptoms, room number/location, culture, where the infection was acquired, and if it was resolved. During interview 1/27/16, at 2:15 p.m. the DON stated RN-C was put in charge of the infection control program at the end of November 2015, when she was hired. The DON stated she was aware the infection control program was lacking many of the required components, and stated she was unaware of the three identified UTI's in October 2015, had not been addressed or investigated. DON stated facility infection concerns were reviewed at the morning meeting of the administration, and antibiotic use in the facility was discussed, and a new flow sheet infection form was started in January 2015, to include more of the required components for an infection control program. Review of the presented flowsheet dated January 2015, identified the facility had three lower respiratory infections, three fungal infections, one pneumonia, and a breast infection. The form identified the residents name, unit, room number, date, infection, site, and antibiotic start date. However, the form continued to lack the culture results, observed symptoms including start and end dates, and date the infection was resolved. During a follow up interview on 1/28/16, at 8:16 a.m. DON stated she was aware the infection control program was lacking tracking, trending, and analysis of facility infections, and she planned to take over responsibility of the infection control program. The facilities Infection Control Policy revised	F 441		

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 _____	02/01/2016

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 441	Continued From page 142	F 441		

12/15, indicated "All residents are to be treated with universal precautions, because any person may be a carrier of an infectious organism. This is the main procedure for the infection control in the building." The policy further indicated "The infection control nurse monitors infections in the building, and gives report to the DON monthly, and as needed."

During observation of insulin administration on 1/27/16, at 7:40 a.m. licensed practical nurse (LPN)-C removed a bottle of Novolin 70/30 insulin from a mobile cart to administer to R57, who was waiting in the hallway. LPN-C, using her bare un-gloved hands, inserted the needle of a insulin syringe and drew up the medication, used a disposable alcohol wipe to clean R57's skin and then inserted the syringe into R57's abdomen and injected the insulin.

When interviewed on 1/27/16, at 7:42 a.m. LPN-C stated staff, "We're supposed to," wear gloves when administering insulin, "In case of any blood."

During interview on 1/27/16, at 7:47 a.m. RN-A stated the nurses should wear gloves with any insulin administration because the resident, "Could bleed." RN-A stated by not wearing gloves when dealing with blood there was a risk staff could, "Potentially infect yourself or them [residents]."

A facility policy on insulin administration was requested, but none was provided.

During observation on 1/27/16, at 8:01 a.m. nursing assistant (NA)-F applied gloves before

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 _____	02/01/2016

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 441	Continued From page 143	F 441		

starting R39's morning cares which included applying her socks and washing her face. Using the same gloved hands, NA-F removed R39's incontinence product, completed perineal cares, and then resumed getting the resident dressed for the day. NA-F was observed to touch the closet door knob, bathroom door, and water faucet during this time, then proceeded to wash R39's upper body, and apply deodorant to her. NA-F removed her gloves, and assisted R39 into her wheelchair and started combing her hair, lotioning her skin, and placing her dentures in her mouth. NA-F did not change gloves after completing perineal cares, or wash her hands after removing her soiled gloves.

During further observation of morning cares on 1/27/16, at 8:24 a.m. NA-F applied gloves and assisted R53 to wash and dry her upper body, apply deodorant, and then removed R53's incontinence product. NA-F removed her soiled gloves, and without washing her hands or using any hand sanitizer, NA-F brushed R53's hair. NA-F then applied new gloves to complete perineal cares using a washcloth and when she was finished she placed the soiled washcloth on the commode. NA-F removed her gloves and handled the soiled washcloth using her bare hands, and then assisted R53 to put on a sweater without completing any hand hygiene.

During another observation of morning cares for R39 on 1/28/16, at 10:53 a.m. NA-E applied gloves and removed R39s soiled incontinence product which contained urine and bowel. R39 was assisted to stand, and NA-E performed perineal cares and then removed the soiled gloves. NA-E continued to perform cares, including touching R39's shoulder and arm,

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 _____	02/01/2016

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 441	Continued From page 144 before assisting R39 into her wheelchair. NA-E did not complete any hand hygiene, including washing and/or using hand sanitizer after removing the soiled gloves. When interviewed immediately following R39's morning cares on 1/28/16, NA-E stated she did not wash her hands after removing her soiled gloves, but she should have. During interview on 2/1/16, at 8:04 a.m. RN-B stated gloves were to be changed and hands should be washed after performing perineal cares, and before starting a new task; and staff should be washing their hands anytime after removing gloves. A facility Handwashing policy dated 12/2014, identified Handwashing was to be performed after assisting a resident with personal care, coming in contact with a resident's skin, assisting a resident with toileting, and removing gloves. An additional facility Gloving, Non-Sterile Technique policy dated 10/2014, identified staff were to wash their hands after removing gloves.	F 441		
F 490 SS=D	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 490	F490	3/11/16

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 _____	02/01/2016

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 490	Continued From page 145 facility failed to ensure administration effectively addressed concerns of neglect and potential for injury for 1 of 1 residents (R77) reviewed who was consuming alcohol in an unsafe manner. Findings include: See F224 as the facility neglected to comprehensively assess, develop interventions, and ensure safety measures were in place to protect 1 of 1 residents (R77) who was consuming alcohol and becoming intoxicated resulting in unsafe behavior. This resulted in actual harm to R77 who required multiple episodes of medical, police, and/or detox intervention as a result of consuming alcohol and becoming intoxicated, and although the facility was aware of R77's unsafe behavior, the facility neglected to ensure interventions were in place to prevent significant injury to R77 and/ or others. See F323 as the facility failed to comprehensively assess and develop interventions to reduce the risk of significant harm to 1 of 1 residents (R77) who was consuming alcohol and becoming intoxicated which resulted in multiple episodes of medical and/or detox intervention. This resulted in an immediate jeopardy situation for R77. During interview on 2/1/16, at 1:39 p.m. the administrator stated the administration of the facility had discussed concerns for R77 as they arose at their IDT (interdisciplinary team) meetings, but he was unaware of the significant concerns identified with R77's alcohol use and unsafe behaviors towards others, and himself. The administrator stated typically if a resident had these types of concerns, he would recommend and implement some special care conferences to	F 490	Rejection Reason: How will staff ensure administration is aware of concerns going on in facility? It is the policy of Talahi Nursing and Rehab Center that management is administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. Administration utilizes daily stand up meeting, IDT and department head meetings to receive information regarding concerns. Staff has access to and are encouraged to use concern forms available throughout the facility to alert Admin of concerns. Education provided to all staff regarding the process of communicating concerns to administration/administrator provided during all staff meeting. The following approaches have been implemented to assure continued compliance. To facilitate a review of processes, Senior Care Solutions, Inc. has been engaged to evaluate current systems and assist with implementation. Administrator has reviewed the job descriptions of all Department Heads to assure that they reflect accurately assigned responsibilities, especially those	

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 _____	02/01/2016

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 490	Continued From page 146 make sure other residents were safe and concerns were addressed effectively, including bringing in additional outside resources if necessary.	F 490	noted in this plan. Administration Policy has been referred to QA Administrator in consultation with consultant and enhanced QA committee□s quality assurance/QAPI efforts in direct response to survey results, as indicated by each tag. The facility alleges that it will be in substantial compliance and complete all action items by: 03/11/16	
F 497 SS=F	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to complete performance reviews	F 497	F497 Rejection Reason: POC says date of	3/18/16

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 _____	02/01/2016

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 497	Continued From page 147 every 12 months for 5 of 5 nursing assistants (NA-M, NA-L,NA-J, NA-K, and NA-I) who were employed by the facility for greater than one year. This had the potential to affect all 71 residents who resided in the facility. Findings include: Nursing Assistant (NA)-M's personal file was reviewed and identified a hire date of 10/30/14. NA-M had not received a performance evaluation within the past 12 months, however, had received counseling on 4/2/15, for using her cell phone while working, and a disciplinary action on 8/21/15, for not answering call lights. NA-L's personal file was reviewed and identified a hire date of 11/28/12. The personal file indicated the last Performance Evaluation was completed on 10/09/13, over two years ago. NA-J's personal file was reviewed and identified a hire date of 10/24/13. The personal file lacked evidence of documentation an employee performance review had been done since hire. NA-K's personal file was reviewed and identified a hire date of 11/14/13. The personal file lacked evidence of documentation an employee performance review had been done since hire. NA-I's personal file was reviewed and identified a hire date of 10/24/13. The personal file lacked evidence of documentation an employee performance review had been done since hire. During interview 2/1/16, at 11:37 a.m. the director of human resources (HR) stated she used to send and e-mail to the director of nursing (DON)	F 497	correction 3/30/16 It is the policy of Talahi Nursing and Rehab Center that direct care staff receive required annual reviews to ensure they are providing safe, effective care to all resident. Process to schedule and complete Nurse Aide reviews and evaluations was reviewed and updated. Schedule was created to complete back evaluations was created and implemented. All evaluations will be completed and current by 03/18/2016 The policy and procedure for completion of employee evaluations was reviewed and is current Education was provided to staff responsible for completing employee evaluations and process implemented. Audits of employee files will be completed weekly for the completion of scheduled evaluations by HR Manager or Designee. The facility alleges that it will be in substantial compliance and complete all action items by: 03/18/16	

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 _____	02/01/2016

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 497	Continued From page 148 until January 2016, to remind her to complete employee performance reviews, and now she sends and e-mail to the DON and the case managers. The HR stated, "The performance evaluations are supposed to be done on a yearly basis, and they should come back to me." The HR director stated she was the one who tracked the employee performance reviews, and stated the employee reviews were not completed. A policy regarding employee performance reviews was requested but not provided.	F 497		
F 501 SS=D	483.75(i) RESPONSIBILITIES OF MEDICAL DIRECTOR The facility must designate a physician to serve as medical director. The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to collaborate with the medical director to address concerns of neglect, and significant potential for serious injury for 1 of 1 residents (R77) reviewed who was consuming alcohol in an unsafe manner. Findings include: See F224 as the facility neglected to comprehensively assess, develop interventions, and ensure safety measures were in place to protect 1 of 1 residents (R77) who was	F 501	F501 It is the policy of Talahi Nursing and Rehab Center that the Medical Director is consulted, updated and involved in substantial VA reports. The Medical Director is contacted by the facility and updated on survey results. VA policy and Procedure is reviewed and current and concurred with Medical Director Interdisciplinary team including Medical Director will have training on QA process by contracted Nurse Consultant. Meeting	3/4/16

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 _____	02/01/2016

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 501	Continued From page 149 consuming alcohol and becoming intoxicated resulting in unsafe behavior. This resulted in actual harm to R77 who required multiple episodes of medical, police, and/or detox intervention as a result of consuming alcohol and becoming intoxicated, and although the facility was aware of R77's unsafe behavior, the facility neglected to ensure interventions were in place to prevent significant injury to R77 and/ or others. See F323 as the facility failed to comprehensively assess and develop interventions to reduce the risk of significant harm to 1 of 1 residents (R77) who was consuming alcohol and becoming intoxicated which resulted in multiple episodes of medical and/or detox intervention. This resulted in an immediate jeopardy situation for R77. During interview on 2/1/16, at 9:10 a.m. the facility medical director (MD)-E stated he was aware R77 had episodes of being intoxicated, but was never informed by facility staff R77 was having his medications held at times due to being intoxicated, and was unable to take them safely. MD-E stated he was unaware R77 had been found intoxicated in the bushes by the bank, was using plastic cutlery because of using silverware as a weapon and past threats of physical harm he had made to staff, or been admitted to a detox facility multiple times since his admission to the facility. MD-E stated he was aware R77 had a pattern of drinking and becoming intoxicated, however, "Not to this extent." MD-E stated if he had been aware, he could have worked with the other medical staff to ensure appropriate responses and interventions were being developed for situations involving R77's unsafe behaviors.	F 501	will identify quality issues, review for trending and root cause analysis, and will develop appropriate plans of action to correct the quality areas identified by committee. Administrator is responsible for overall compliance. Education on coordination and collaboration with Medical Director in cases of potential VA completed with IDT and Medical Director Audits of VA reports for acceptable collaboration with Medical Director weekly by IDT, quarterly by QA The facility alleges that it will be in substantial compliance and complete all action items by: 03/04/16	

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 _____	02/01/2016

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 501	Continued From page 150 During interview on 2/1/16, at 1:39 p.m. the director of nursing (DON) stated she first reached out to include MD-E when concerns were brought up by the survey team the week prior (during the recertification survey). The DON stated MD-E had not been included in R77's care because she thought he was already aware of the situation. A facility supplied Medical Director Agreement dated 1/2013, identified, "Responsibilities Of Medical Director," and included a numerical list of responsibilities including, "Overall coordination of medical care in the facility to ensure the adequacy and appropriateness of the medical services provided to residents."	F 501		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.	F 520		3/4/16

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 _____	02/01/2016

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 520	Continued From page 151 Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Quality Assessment (QA) committee recognized and developed action plans to address neglect and potential for injury for 1 of 1 residents (R77) who was consuming alcohol, becoming intoxicated, and was a danger to himself and other residents. In addition, the QA committee failed to develop an action plan to address an identified lack of timely reporting of potential abuse and neglect to the State agency. These deficient practices had potential to affect all 71 residents in the facility. Findings include: See F224 as the facility neglected to comprehensively assess, develop interventions, and ensure safety measures were in place to protect 1 of 1 residents (R77) who was consuming alcohol and becoming intoxicated resulting in unsafe behavior. This resulted in actual harm to R77 who required multiple episodes of medical, police, and/or detox intervention as a result of consuming alcohol and becoming intoxicated, and although the facility was aware of R77's unsafe behavior, the facility neglected to ensure interventions were in place to prevent significant injury to R77 and/ or others. See F225 as the facility failed to ensure allegations of mistreatment were were	F 520	F520 It is the policy of Talahi Nursing and Rehab Center that QA committee will meet in a timely manner per policy and regulations and that the QA committee will recognize and develops actions plans to address potential neglect and injury. QA meets at a minimum on a quarterly basis and identifies quality issues and action plans developed. The agenda for the QA committee meeting has been reviewed and updated. QA met on 02/23/16 to review state survey findings and review POC and action plan The policy for the QA committee was reviewed and revised. The committee will receive education from contracted Nurse Consultant on identification of quality issues, identification of patterns and trends, and development of action plans to correct areas identified. The policy for the QA committee was reviewed and revised. The committee will receive education from contracted Nurse Consultant on identification of quality issues, identification of patterns and trends, and development of action plans to correct areas identified. Administrator is responsible for overall	

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 _____	02/01/2016

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 520	Continued From page 152 immediately reported to the administrator and the State agency for 5 of 6 residents (R50, R77, R76, R82, R70), and failed to ensure a complete investigation was submitted to the State agency for 1 of 6 residents (R77) whose allegations of mistreatment were reviewed. See F226 as the facility failed to implement abuse policies and procedures to include consistent, immediate reporting of allegations of mistreatment to the administrator and State agency for 5 of 6 residents (R50, R77, R76, R82, R70), whose allegations were reviewed. In addition, the facility failed to ensure a comprehensive investigation was submitted to the State agency for 1 of 6 residents (R77) with allegations of mistreatment. See F323 as the facility failed to comprehensively assess and develop interventions to reduce the risk of significant harm to 1 of 1 residents (R77) who was consuming alcohol and becoming intoxicated which resulted in multiple episodes of medical and/or detox intervention. This resulted in an immediate jeopardy situation for R77. On 2/1/16, at 1:50 p.m. the director of nursing and administrator were interviewed regarding the facilities' Quality Assessment and Assurance (QA&A) program. The DON stated the lack of timely reporting related to their vulnerable adult and abuse reports had been identified as a concern, however, an action plan had never been developed to address how to resolve the issue by the QA committee. The DON stated the timely reporting of potential abuse and neglect would be addressed in their QA program going forward. DON stated the administration would bring up concerns regarding R77 consuming alcohol	F 520	compliance. The facility alleges that it will be in substantial compliance and complete all action items by: 03/04/16	

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 _____	02/01/2016

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 520	Continued From page 153 frequently and threatening the staff, however, the QA&A committee had not developed an action plan to address R77's safety, or the ensure the safety of all the other residents in the facility due to R77's behaviors while intoxicated. An undated facility Quality Assessment / Assurance Plan policy identified several objectives of the QA&A committee including, "Assist individual department's staff to improve resident care, to monitor and to evaluate departmental activities and services," and, "Evaluate the results of actions taken by individual departments and maximize the efficient use of resources available within the Facility and the community." The policy indicated, "The Quality Assessment/Assurance Committee is responsible for assuring that activities are directed toward the continuous improvement of care," which included a bulleted list identifying, "Appropriate actions are implemented to eliminate or reduce identified problems or otherwise improve care to the greatest degree reasonable [sic] possible."	F 520		
F 522 SS=C	483.75(p) DISCLOSURE OF OWNERSHIP REQUIREMENTS The facility must comply with the disclosure requirements of §§420.206 and 455.104 of this chapter. The facility must provide written notice to the State agency responsible for licensing the facility at the time of change, if a change occurs in persons with an ownership or control interest, as defined in §§420.201 and 455.101 of this chapter; the officers, directors, agents, or managing employees; the corporation, association, or other	F 522		2/18/16

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 _____	02/01/2016

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 522	Continued From page 154 company responsible for the management of the facility; or the facility's administrator or director of nursing. The notice specified in the paragraph (p)(2) of this section must include the identity of each new individual or company. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the State agency was notified of a new director of nursing and administrator being appointed. This had potential to affect all 71 residents currently residing in the facility. Findings include: An undated facility supplied listing of current staff identified the director of nursing (DON) was hired on 5/26/15, to her position. During the extended survey, documentation was requested to verify the State agency (MDH) was notified when the director of nursing and administrator were appointed to their positions at the facility. During interview on 2/1/16, at 1:50 p.m. the administrator stated the facility had no documentation to verify the State agency had been notified of the administration personnel changes, and he expected corporate would have notified the state agency. No further information was provided.	F 522	F522 It is the policy of Talahi Nursing and Rehab Center that any change in management in the positions of Administrator, Director of Nursing, Ownership or Management Company will be reports to the appropriate State/Federal departments. The appropriate state agency was notified of new Administrator and Director of Nursing State regulation regarding notification of change in management/owner ship provided to current DON/Administrator and Owner/management Company Each change of Administer and Director of Nursing, the appropriate state agency is notified. The facility alleges that it will be in substantial compliance and complete all action items by: 02/18/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245438	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/26/2016**

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
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 not 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date.	K 000	EPOC	

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

Electronically Signed — 02/26/2016

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245438	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/26/2016**

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
K 000	Continued From page 1 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency 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 monitored for automatic fire department notification. The facility has a licensed capacity of 77 beds and had a census of 71 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245438	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/26/2016**

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
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on an interview with staff, the facility has failed to ensure that emergency lighting has been tested in accordance with NFPA LSC (00) Section 7.9, 19.2.9.1. This deficient practice could affect all patients, staff and visitors in the event of an emergency evacuation during a power outage. Findings include: On facility tour between 9:30 AM and 2:00 PM on 01/26/2016, during the review of available emergency battery back up exit lighting maintenance documentation and interview with the Maintenance Supervisor revealed the that the facility failed to conduct a 90 minute test for the battery back up lighting within the last 12 months. This deficient practice was confirmed by the Maintenance Supervisor.	K 046	K046 Emergency lighting will be tested in accordance with NFPA LSC (00) Section 7.9, 19.2.9.1. The policy and procedure was reviewed and updated. A 90 minute test for the battery pack will be done on an annual basis. Maintenance staff, Administrator and Assistant Administrator have been educated on regulations involving testing of emergency light. Safety Committee will audit the monthly testing in preparation for the annual testing.	3/25/16
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2	K 050		3/25/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245438	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/26/2016**

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
K 050	Continued From page 3 This STANDARD is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to adequately track employee participation for each shift in the last 12-month period in accordance with NFPA 101 LSC (00) Section 19.7.1.2. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect all patients. Findings include: On facility tour between 9:30 AM and 2:00 PM on 01/26/2016, record review revealed the third shift of the second quarter fire drill was not conducted. This deficient practice was confirmed by the Maintenance Supervisor.	K 050	K050 An annual schedule for fire drills has been compiled and will be followed. It includes drills for each shift on an alternating basis. Education was provided to all staff to explain the purpose and process of fire drills. Safety Committee will review fire drill records on a monthly basis.	
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, it was revealed that the facility had failed to install and	K 052	K052 An annual schedule for conducting	3/25/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245438	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/26/2016**

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
K 052	Continued From page 4 maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1999 NFPA 72, Sections 7.1. This deficient condition could adversely affect the functioning of the fire alarm system, and could delay the timely notification and emergency actions for the facility thus negatively affecting all residents, staff, and visitors of the facility. Findings include: On facility tour between 9:30 AM and 2:00 PM on 01/26/2016, a review of all available fire alarm documentation for the last 12 months, and an interview with the Maintenance Supervisor, revealed that at the time of the inspection the facility had failed to conduct 5 of 12 required monthly tests of the DACT for the facility's fire alarm system. This deficient practice was confirmed by the Maintenance Supervisor.	K 052	required monthly tests of the DACT has been developed. Maintenance staff, Administrator and Assistant Administrator have been educated on the testing requirements. Safety Committee will review testing documentation at the monthly Safety Committee meeting.	
K 054 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on interview and review of available documentation, the facility has not been conducting sensitivity testing of the smoke detectors on the fire alarm system in accordance with NFPA 72 (99), Sec. 7-3.2.1. This deficient	K 054	K054 Fire alarm, smoke detectors and heat detectors are scheduled to be tested by a professional on an annual basis or as directed by the manufacturers	3/25/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245438	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/26/2016**

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
K 054	Continued From page 5 practice could affect all residents, visitors, and staff. Findings include: On facility tour between 9:30 AM and 2:00 PM on 01/26/2016, a review of the facility's available fire alarm test documentation revealed that the facility failed to conduct the required sensitivity test of each smoke detector. The last smoke detector sensitivity test was conducted was unclear. This deficient practice was confirmed by the Maintenance Supervisor.	K 054	specifications. Testing is recorded on the "Fire Alarm Inspection and Testing Form" provided by the testing company. Maintenance staff, Administrator and Assistant Administrator have been educated on the requirement of K054. Reviewed forms and all tests are current.	
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, record review and interview the complete automatic fire sprinkler system is not being maintained in accordance with NFPA 25(99) Section 9.2.7. This deficient practice could effect all occupants of the building if the system were to fail under fire conditions. Findings include: On facility tour between 9:30 AM and 2:00 PM on 01/26/2016, it was observed and revealed during review of available fire sprinkler records that: 1) There was no documentation for quarterly sprinkler flow testing in the 4th quarter.	K 062	K062 The quarterly sprinkler flow testing is scheduled on the annual calendar. Maintenance Staff, Administrator and Assistant Administrator have been educated on the schedule for the flow testing. The Safety Committee will monitor the process during the monthly meeting.	3/25/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245438	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/26/2016**

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
K 062	Continued From page 6 This deficient practice was confirmed by the Maintenance Supervisor.	K 062		
K 066 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observations and interview, the facility has failed to properly enforce the facility smoking policy. This deficient practice could affect all residents. Findings include: On facility tour between 9:30 AM and 2:00 PM on	K 066	K066 Smoking regulations have been reviewed. All smokers have an smoking assessment by a licensed nurse. Smoking lounge is open during limited hours for smoking and has a staff member present when open for smoking activity.	3/25/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245438	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/26/2016**

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
K 066	Continued From page 7 01/26/2016, observation revealed paper in the butt can and a resident that resides in the Assisted Living, putting out a cigarette in the butt can with paper in it in the smoking lounge. This deficient practice was confirmed by the Maintenance Supervisor.	K 066	Staff has been educated regarding the new policy for the smoking lounge. The new policy for the Smoking Lounge was presented to the resident's council, smokers, and smoker's responsible parties. During random resident and staff interviews, staff and residents will be asked if they know the smoking policy. Safety in the Smoking Lounge will be reviewed during the monthly Safety Committee.	
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, that the facility's general ventilating and air conditioning system (HVAC) was not maintained in accordance with the LSC, Section 19.5.2.1 and NFPA 90A, Section 3-4.7. A noncompliant HVAC system could affect all patients, visitors and staff. Findings include: On facility tour between 9:30 AM and 2:00 PM on 01/26/2016, documentation review for fire damper testing for the past 4 years revealed, that the fire/smoke dampers have not been tested. Last documented testing was in 2009.	K 067	K067 Facility's general ventilating and air conditioning system will be maintained in accordance with LCS requirements. The testing will be done by an outside professional firm. Maintenance Staff, Administrator, Assistant Administrator and Safety Committee have been educated on the testing requirements. This will be a standing agenda item for review by the Safety Committee.	3/25/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245438	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/26/2016**

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
K 067	Continued From page 8 This deficient practice was confirmed by the Maintenance Supervisor.	K 067		
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to inspect the emergency generator in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 Chapter 6-4.1. The deficient practice could affect all patients, visitor and staff. Findings include: On facility tour between 9:30 AM and 2:00 PM on 01/26/2016, documentation review of the weekly/monthly inspection logs three weeks during the month of December 2015 and the monthly for December2015 for the diesel emergency generator revealed that the weekly operational inspection were missed. This deficient practice was confirmed by the Maintenance Supervisor.	K 144	K144 The weekly operational inspection will be added to the annual calendar. maintenance staff will complete the inspection. Maintenance Staff, Administrator, Assistant Administrator and Safety Committee have been educated on the testing requirements. The schedule will be reviewed monthly by the Safety Committee.	3/25/16