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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: IXBL

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 **04/23/2018** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
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):
A recertification survey was conducted February 26, 2018 through March 1, 2018, and complaint investigation(s) were also completed at the time of the standard survey. At the time of the survey, an investigation of complaints: H5438053, H5438054, H5438055, and H5438056 were completed and were all found to be unsubstantiated.

17. SURVEYOR SIGNATURE — Date :
Kathleen Lucas, Unit Supervisor — 05/02/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Joanne Simon, Enforcement Specialist — 05/02/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/03/2018
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245438

May 2, 2018

Ms. Marlene Smith, Administrator
Talahi Nursing and Rehab Center
1717 University Drive Southeast
Saint Cloud, MN 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 April 10, 2018 the above facility is 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,

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

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 2, 2018

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

RE: Project Number S5438029, H5438053, H5438054, H5438055 and H5438056

Dear Ms. Smith:

On March 16, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 1, 2018 that included an investigation of complaint number H5438053, H5438054, H5438055 and H5438056. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On April 23, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on April 11, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard our facility had corrected these deficiencies as of April 10, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 1, 2018, effective April 10, 2018 and therefore remedies outlined in our letter to you dated March 16, 2018, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: IXBL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00614

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(L1) **245438**
2.STATE VENDOR OR MEDICAID NO.
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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 **03/01/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
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X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	77			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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A recertification survey was conducted February 26, 2018 through March 1, 2018, and complaint investigation(s) were also completed at the time of the standard survey. At the time of the survey, an investigation of complaints: H5438053, H5438054, H5438055, and H5438056 were completed and were all found to be unsubstantiated.

17. SURVEYOR SIGNATURE — Date :
Carlene Lange, HFE NE II — 03/28/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Amy Johnson, Enforcement Specialist — 04/02/2018 (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:

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
02/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 16, 2018

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

RE: Project Numbers S5438029, H5438053, H5438054, H5438055, H5438056

Dear Ms. Smith:

On March 1, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the March 1, 2018 standard survey the Minnesota Department of Health completed an investigation of complaint numbers H5438053, H5438054, H5438055, H5438056, that were found to be unsubstantiated.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567 whereby corrections are required.

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

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

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

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

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6

months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Kathleen Lucas, Unit Supervisor
St. Cloud B Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: kathleen.lucas@state.mn.us
Phone: (320) 223-7343
Fax: (320) 223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 10, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by April 10, 2018 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

Your ePoC must:

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the

Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by June 1, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as

mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 1, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety

State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Michaelyn Bruer, Enforcement Specialist
Minnesota Department of Health
Health Regulation Division
Program Assurance Unit
phone 651-201-4117 fax 651-215-9697
email: michaelyn.bruer@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245438	A. BUILDING _____ B. WING _____	C 03/01/2018

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
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted 02/26/18 through 03/01/18, during a recertification survey. The facility was not compliance with the Appendix Z Emergency Preparedness Requirements. See K-tags.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted February 26, 2018 through March 1, 2018, and complaint investigation(s) were also completed at the time of the standard survey. At the time of the survey, an investigation of complaints: H5438053, H5438054, H5438055, and H5438056 were completed and were all found to be unsubstantiated. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and	F 550		3/23/18

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

Electronically Signed | 03/23/2018

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 _____	C 03/01/2018

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 550	Continued From page 1 outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide personal care	F 550	Preparation and/or execution of this report of correction does not constitute	

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 _____	C 03/01/2018

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 550	Continued From page 2 assistance to promote dignity for 1 of 1 resident (R55) observed after having an emesis. Findings include: R55's Admission Record dated 1/17/17, included diagnosis of multiple sclerosis, tumor of the stomach, lung cancer, severe depression, and malnutrition. The quarterly Minimum Data Set (MDS), dated 2/12/18, indicated R55 had moderate cognitive impairment, displayed feelings of being down and hopeless, required extensive assistance for personal hygiene. The MDS indicated R55 had no behavior issues and did not reject cares. In addition, the MDS indicated R55 was totally dependent on staff for eating, and had a feeding tube. A Care Area Assessment, dated 10/20/17, included R55 needed extensive assistance with ADLs, including personal hygiene, related to weakness, gastrointestinal issues, tube feeding, and limited mobility. R55's care plan, revised on 11/22/17, identified a self-care performance deficit related to fatigue and impaired balance, and a need for extensive assistance with personal hygiene and oral care. The care plan directed staff to, "brush teeth with extensive assist of 1," in the morning, after meals, and at bedtime. The care plan also identified R55 was totally dependent on staff for eating with tube feeding and was NPO (nothing by mouth). Review of the AM GROUP 3 nursing assistant care sheet, undated, identified R55 was NPO, and was to have no ice chips. There was no direction for oral cares. Review of R55's Order Summary Report,	F 550	admission or agreement by the provider of the truth of the facts set for in the statement of deficiencies required by the provisions of the federal and state law. F550 It is the policy and procedure of Talahi Nursing and Rehab to treat each resident with respect and dignity in an environment that promotes quality of life and individuality at all times. The Director of Nursing (DON) was made aware on 3/1/18 that oral cares were not provided for R55 after an emesis. All licensed staff were immediately re-educated on the policy and procedure for providing proper oral care. R55 was immediately provided oral care. All other residents requiring extensive assist with oral cares are being provided that care as evidenced by 100% compliance by observation of cares by the RN Case Managers and review of documentation. Policy and Procedure titled: Mouth/Oral Care was revised to include oral care monitoring for residents with tube feedings, NPO and extensive assist. Acute charting has been added to the MAR, and is reviewed daily by the RN Case Managers and DON, to ensure that all residents that are NPO, tube feeders or require extensive assist are receiving oral care. All care sheets updated to reflect need for oral care.	

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F 550	Continued From page 3 undated, included, "Nurse to ensure the resident is offered and assisted with oral cares. Use oral swabs, APPLY CHAPSTICK PRN. every shift for Oral Cares." Review of R55's Medication Administration Record (MAR) for 1/1/18-1/31/18, and 2/1/18-2/28/18 included "Nurse to ensure the resident is offered and assisted with oral cares. Use oral swabs, APPLY CHAPSTICK PRN. every shift for oral cares," with an order dated of 11/29/17. Staff have documented initials each day, at 6:00 a.m., 3:00 p.m., and 11:00 p.m. During an observation on 2/27/18, at 8:27 a.m. R55 was lying in bed, retching, and vomited a moderate amount of dark liquid with thick mucous into a pink basin. R55 had no tissues in her room, so used her hand to wipe vomit off her chin, and pushed her call light button. An unidentified female staff member came into the room, and took the basin into the bathroom to empty and clean it. The staff returned the basin to R55, raised the head of her bed and turned off R55's tube feeding. Without offering to assist R55 with cleaning her face or offer oral care, the staff left the room. When interviewed on 2/27/18, at 8:43 a.m. R55 stated, "I used to tell them I wanted to brush my teeth. They never offer. I would go into the bathroom by myself but that's a no no. They probably think I'm going to drink water or something." R55 looked down, and stated, "It used to bother me when I first came in, but I'm just used to it now." During an observation on 2/27/18, at 2:34 p.m. R55 stated she was still not feeling well. Thick, clear, stringy saliva was noted between R55's top and bottom lips as she talked and a thick white	F 550	Audits will be completed for three residents three times per week for minimum of six weeks, to ensure dignity has been provided to R55, as well as all resident in the facility regardless of NPO, or tube feeding status. The IDT/QAPI to meet monthly to evaluate outcomes of these audits and determine appropriate action to follow or make recommendations.	

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substance was noted on her top front teeth. R55 used her right hand to cover her mouth at times while she spoke. R55 stated she hadn't been offered oral care or brushed her teeth and stated "they never do."

When interviewed on 2/28/18, at 8:14 a.m. R55 stated she was "getting rid of phlegm today," and thick clear sputum was noted in a pink basin beside her on the bed. As she spoke, R55 had thick white substance on her teeth and at the corners of her mouth, and thick stringy saliva was noted between her lips as she talked. R55 stated she hadn't brushed her teeth "in a long time, weeks maybe months." R55 stated, "I feel like they just want me to clean myself up after I vomit, but I don't have anything to do that. They don't give me anything." R55 indicated one nursing assistant helped her brush her teeth a long time ago, and stated, "it felt so good." R55 stated, "They have told me they'll get fired if they get caught helping me brush my teeth, because I might drink water. They're told they can't give me anything. They used to occasionally give me a dry pink sponge swab. That's just gross." R55 stated she likes to go to play bingo and it used to bother her to be around other residents because her teeth weren't brushed, but stated, "I try not to let it bother me now. It's just how it is." At 9:42 a.m., R55 was observed to be dressed and sitting up in her bed. R55 stated she was given a washcloth and was able to wash her face, but wasn't offered oral cares or to brush her teeth. R55 looked down, and stated, "I'm just used to it."

During an interview on 2/28/18, at 12:24 p.m. nursing assistant (NA)-G stated he couldn't remember if he had assisted R55 with oral cares that morning because he had been running all

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F 550	Continued From page 5 over, but stated he would check with R55. When NA-G asked R55 if she had swabbed her mouth today, R55 stated she hadn't had oral cares in "a long time." NA-G stated usually the nurses do R55's oral care and that they are his boss, so if they told him to do oral cares, he would it. NA-G stated, "If she [R55] drinks water, she will throw up." When interviewed on 2/28/18, at 12:42 p.m. licensed practical nurse (LPN)-C stated there was absolutely no reason staff shouldn't be helping R55 with personal hygiene and oral cares. LPN-C indicated nurses were to document every shift that R55 had been offered and assisted with oral cares. When asked how she ensured that R55's oral cares were being done before documenting with initials on the MAR, LPN-C stated, "I just assumed that it was being done, that's part of their cares." LPN-C stated she would be re-educating the nursing assistants that they must be brushing R55's teeth. LPN-C stated, "That's awful, I just assumed that they were doing it." During an interview on 3/1/18, at 9:40 a.m. the assistant director of nursing (ADON) indicated they had "triggered oral cares," for the cart nurse to check to ensure that R55's oral cares were being done every shift. The ADON stated R55 was "always verbalizing that she's dry," and added, "There's no problem with her doing oral cares." Review of the facility's policy, Resident's Privacy and Dignity, dated 12/25/16, indicated, "It is the policy of Talahi Nursing and Rehab to provide dignity and privacy for our residents at all times."	F 550		
F 577	Right to Survey Results/Advocate Agency Info	F 577		4/2/18

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F 577 SS=C	Continued From page 6 CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to post notice of availability of the last three years of State Agency survey results. This had the potential to affect all 73 current residents, visitors, and staff who wished to review this information. Findings include: During an observation on 2/27/18, at 1:12 p.m. a	F 577	Preparation and/or execution of this report of correction does not constitute admission or agreement by the provider of the truth of the facts set for in the statement of deficiencies required by the provisions of the federal and state law. It is the policy and procedure of Talahi Nursing and Rehab to provide all residents, families and visitors with	

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F 577	Continued From page 7 framed sign was noted on the wall in a sitting area near the entrance of the facility, that included "Talahi Nursing & Rehab's most current survey results are located on top of the reception desk at the main entrance." Upon further observation, a white 3-ring binder was noted sitting on top of the reception desk with "Survey Book" on the front cover. The 3-ring binder contained a copy of the Minnesota Department of Health survey results, dated 12/8/16, and a complaint survey from 8/23/17. No additional survey results were in the binder, and there was no signage notifying residents, family, and staff that survey results during the three preceding years were available for any individual to review upon request. During an interview on 2/26/18, at 5:31 p.m. the administrator stated only the most recent survey results were posted. The administrator stated she was not aware three years of survey results needed to be available and that she had already changed the sign. No further information was provided.	F 577	access to our survey results. Staff were informed on 2/27/2018 during the survey process that the framed sign posted on the wall near the entrance to the facility displayed that the survey results for that past year were available at the front desk. The Administrator and Social Services Director immediately printed off a new posting stating, “Talahi Nursing and Rehab makes available the last three years of survey results. The most recent copy of the results are located on top of the reception desk at the main entrance. The prior years are available upon request”. The residents will be notified of this change at a special Resident council Meeting on Wednesday March 28, 2018 at 3:30 PM. A copy of all previous survey results are available in our business office and will be provided upon request. Immediate compliance with education provided to Social Service Director to ensure resident rights are being followed according to state and federal guidelines. The IDT/QAPI to meet monthly for appropriate recommendations. Administrator/Social Service Director/Designee is Responsible	

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F 603 SS=D	Free from Involuntary Seclusion CFR(s): 483.12(a)(1) §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and provide supporting, objective clinical justification to have 1 of 1 residents (R13) in the locked memory care unit resulting in seclusion from activities of interest. Findings include: The Minnesota Department of Health (MDH) Information Bulletin 91-1 NH-1 dated 4/22/08, identified a locked unit is considered a "form of restraint," and a wavier would be needed to construct a locked unit. The bulletin listed guidelines for locked nursing units which included compliance with applicable rule(s), MDH approval and review of applicable policies and physical plant requirements. A section labeled, "Written Policies," identified the unit must have "...policies with criteria and procedures for admission and	F 603	Preparation and/or execution of this report of correction does not constitute admission or agreement by the provider of the truth of the facts set for in the statement of deficiencies required by the provisions of the federal and state law. Talahi Nursing and Rehab does exercise resident's rights to be free from Involuntary Seclusion. An Admission criteria, process, transfer/discharge was revised on 3/19/2018 and will be implemented upon admission to the memory unit, and quarterly with care conferences. An Assessment of Admission and Continuation of Placement on Rosewood Memory Unit was developed and will be	4/2/18

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F 603	Continued From page 9 demission of residents to and from the unit," along with a written plan of care written for each resident and, "A policy for ongoing observation by staff or any member of a disciplinary team for the need of continued placement of each resident in the locked unit, including a policy for specific time periods for formal reassessment of such need, must be provided. Review of residents should be at least quarterly." A Rosewood Admission Criteria was provided by the facility which was identified as last being reviewed by the Quality Assurance (QA) committee on 5/24/17. It listed the criteria for admission to the locked unit which included: - Must have supporting diagnosis of Alzheimer's disease, encephalopathy, dementia, or other related disorder, - Must have a physician's order for skilled nursing care, - Must exhibit a need for secure environment due to safety, - Must not be a threat or harm to self or others, - Must have a primary physician who makes nursing home visits or caregiver who will take the resident to their physician on a monthly or as-needed basis, - Must have a medical power of attorney (POA) or guardian prior to admission, - Must have private long-term care insurance, Medicaid or be private pay and, - Must have a complete current history and physical prepared by a primary physician. The provided listing lacked any dictation identifying how often these criteria are reviewed, nor information on how often a resident is reassessed against these criteria for placement in	F 603	implemented upon admission as well as assessed at least quarterly with care conferences to ensure proper placement and continuation of care for our Rosewood Memory Unit. R13 was immediately assessed for continuation of placement in the secured unit. R13 is appropriately placed. All other residents have been assessed to assume proper placement. All Nursing staff educated on the new Admission process/criteria for placement to the Memory Unit. The IDT/QAPI to meet monthly for appropriate recommendations to ensure compliance. Social Service Director/Administrator/DON/Designee is Responsible	

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the secured unit.

R13's quarterly Minimum Data Set (MDS) dated 11/27/17, indicated R13 had intact cognition with no changes in her cognition from her baseline. R13 required no physical assistance to complete her activities of daily living (ADLs) including bed mobility, transfers, dressing and ambulation. R13 demonstrated no psychosis, nor any verbal, physical or other behavioral symptoms (defined as hitting or scratching themselves, pacing, rummaging or disrobing in public spaces). Further, R13 demonstrated no evidence of wandering during the review period.

R13's care plan dated 1/25/18, indicated R13 was independent with her dressing, bed mobility, eating, transfers and toileting needs. R13 was listed as "may have little to no activity involvement" due to her anxiety, to which staff allow her to leave any time she wishes and monitor her activity involvement. R13 had impaired verbal communication related to her anxiety and cancer diagnoses evidenced by "loss of focus and fixation of irrelevant topics during conversations." The staff approached this by attempting to meet and anticipate her needs, being conscious of her position while in group(s), allowing adequate time to respond and requesting clarification as needed. Further, R13 had impaired judgement and decision making skills, an appointed guardian in place and "difficulty managing her anger at times." The staff responded to this with cueing, reorientation and supervising as needed along with keeping R13's routine consistent to decrease confusion. The care plan lacked any identified notation regarding R13 being placed in a secured unit, the criteria used to determine R13 was appropriate for

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placement in a secured unit, nor any evidence or dictation under which circumstances R13 was or would be allowed to leave the unit on her own.

During interview on 2/26/18, at 3:55 p.m. R13 raised several concerns with living at the nursing home. R13 expressed she did not always get along with her roommate and stated the room mate "bitches at me," if the lamp is left on too long at night. This was frustrating to R13 as she wanted to read at night. R13 stated she was fearful she would drive herself "crazy." R13 explained she did not feel she had any choice or control over her life while at the nursing home. R13 "treasured" the days she could go be outside and walk around adding when she asked staff to go outside now, it was "no dice." R13 stated she thought she lost "a lot of muscles" from not being able to go outside as she desired and stated staff "denied me" the ability to do so.

R13's physician progress note dated 3/29/17, identified R13 had probable moderate dementia. The physician documented he felt there were, "...concerns about safety," given her decreased insight to her limitations, however, added, "she is functioning at a higher cognitive level than almost everyone else on the unit, and if we determine that she is not a significant elopement risk, I thinks she would do better on the open unit, and I could see her potentially flourishing in a memory care assisted living." Further, a subsequent Physician Communication Form dated 5/3/17, identified R13 displayed signs of dementia with decreased safety awareness and insight. The form dictated, "Is at elopement risk and strongly recommend secure facility with permanent guardianship." There were no additional physician order(s) identified to demonstrate a

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continued, ongoing need for a secured, locked unit.

R13's medical record was reviewed and lacked any comprehensive assessment of R13 to determine why she required secured unit placement. There was no evidence of supporting criteria identified to determine why R13 was placed in a secured unit versus living in the general population, nor any reassessment after her admission to justify keeping her secluded inside a locked unit. Further, there was no evidence R13 was identified to wander with intention to elope from the unit.

When interviewed on 3/1/18, at 9:35 a.m. nursing assistant (NA)-E stated R13 spent a lot of time sitting in her room and "looking out the window."

During interview on 3/1/18, at 11:24 a.m. registered nurse (RN)-E stated R13 has reported several times of wanting to go outside, dating back to last summer. RN-E explained R13 did not 'cognitively' have to reside on the locked unit, and had been asked prior if she wanted to move off the unit, however, declined at the time.

On 3/1/18, at 1:25 p.m. R13 was seated in the commons area with others watching a television program. R13 appeared clean and well groomed.

When subsequently interviewed on 3/1/18, at 1:27 p.m. NA-E stated R13 had never tried to elope or wander which she could recall and stated R13 was a "woman of few words." NA-E stated she was unaware why R13 resided in the locked unit of the nursing home.

During interview on 3/1/18, at 1:42 p.m. licensed

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practical nurse (LPN)-B stated R13 was forgetful at times and would "lash out" at staff as she was frustrated and would say she needed to "get out of here." LPN-B explained she had never observed R13 to wander or attempt to leave the unit though. LPN-B was unaware why R13 resided on the locked unit versus being able to live in the general population of the nursing home.

On 3/1/18, at 2:13 p.m. licensed social worker (LSW)-A and registered nurse (RN)-E were interviewed regarding R13 residing on the locked unit. A note was provided which was authored by the director of nursing (DON) from June 2017; in which DON had approached R13 and asked her about changing rooms. However, LSW-A added this was the "last documentation" which could be located regarding her placement or preference for rooming on the unit.

R13's progress note dated 6/13/17, identified the DON "...called and spoke with residents daughter regarding the order/request for resident to move from the memory unit." R13's daughter was identified as having no preference(s) of room for R13; so DON then " ...spoke with resident and she does not want to move. States 'I like my room and roommate and my friends I am comfortable here." The note identified R13's physician was updated and staff would, "Continue to monitor." The note lacked any evidence regarding which, if any, of the risks versus (vs) benefits of remaining on a locked unit were reviewed with R13, including having less ability to ambulate outside unsupervised.

LSW-A stated R13 had current physician orders to be on the locked unit, as the hospital provided

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

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them upon her discharge with dictation of her disposition being, "Talahi Memory Care." LSW-A expressed none of R13's subsequent physician orders identified her to requiring locked memory care services when she reviewed the record, with "just that one comment" from the dismissing hospital physician directing her to a memory care setting. LSW-A explained the criteria for determining placement in the locked unit. This criteria included if someone is at risk for elopement (leaving or wandering away without staff knowledge) or needing activities and care provided on a more consistent routine. LSW-A added the facility takes many cues from the discharging hospital on the resident's specific needs, including if they may benefit from a locked care setting. LSW-A explained there was "no assessment" completed of residents inside the unit using objective, measurable criteria to determine if they required the locked setting or could reside in the general population adding staff were merely "given a sheet" which directed the room a new resident would be admitting to. Further, LSW-A stated a residents' placement on the unit was not revisited or formally reassessed and she was "on the fence," if R13 required a locked memory care unit or not.

During interview on 3/1/18, at 3:05 p.m. the DON stated a resident must have dementia along with a physician order to reside on the memory care unit. The hospital was able to recommend these placements, as well, which is discussed again on admission to the nursing home. R13 had "so many issues" when she admitted (March 2017) and displayed several behaviors, however, staff were going to remove her from the unit once before and she chose to remain; which was dictated in her June 2017 progress note. DON

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stated the placement should be revisited on a quarterly basis during care conference and documented accordingly in a social services note.

DON explained the administrator did have an assessment of a residents' need for locked unit placement, however, added she was unaware how well it had been implemented to this time. The admission criteria for the locked unit was reviewed. R13 had an order on her hospital History and Physical (H&P) for Talahi Memory Care, which was correct as the facility had several "different names" for it. DON stated in June 2017, R13's physician and staff felt she was no longer appropriate for the locked unit, however, again added R13 did not want to move at this time. R13 had not been re-approached since then regarding leaving the locked unit and moving to the general population, however, DON added she felt this was addressed during care conferences when residents are asked if they have any concerns with their room(s). During this interview, the administrator entered the room and stated they did not have any formal locked unit criteria they could provide which had been reviewed and/or approved by the State agency. The administrator stated this had to have been completed when the unit opened before she started adding, ownership of the building had changed "several times" and they were still being taxed and reimbursed on the beds.

An Admission Criteria for Placement on the Secured Memory Care Unit was provided dated 2/2013. This was listed in the corner of the face sheet as a Volunteers of America (VOA) policy and lacked any facility logo or branding. This policy identified the unit was designed for those with Alzheimer's disease and related to dementia

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or whose emotional and behavioral characteristics match those with an individual with dementia. It added, "When the resident no longer requires a secured environment, a transfer or discharge from the unit will be assessed by interdisciplinary team as appropriate." A listing of admission criteria was provided which included:

- A physician's order is required for admission;
- Admission will require any diagnosis that has symptoms or characteristics which may include, short term or long term memory loss, short attention span(s) which impairs concentration to perform and continue tasks, difficulty with communicating own needs, impaired judgement to protect self from harm or injury, impaired judgement in interacting with others, display of delirium or disorientation, exhibits characteristics which are challenging with the general population, wanders with risk for elopement and/or spouse/significant other not requiring memory support program;
- Resident participates in programming to extent of their abilities;
- Less restrictive alternatives have been considered and/or attempted for behaviors and have been deemed unsuccessful;
- Resident is bed bound or confined to bed are not appropriate;
- Resident(s) with current abusive behaviors which may endanger self or others will not be considered for placement;
- A resident which requires 1:1 monitoring will not be considered for placement;
- Respite care for short-term admissions will be planned in advance;
- Responsible party is available for consent for placement to secure unit;
- Residents with feeding tubes, catheters, or other

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F 603	Continued From page 17 medical devices will be assessed on a case by case basis and; - Exceptions to admission criteria will be determined by the interdisciplinary team on a case by case basis. No policies and/or procedures were provided regarding the discharge of a resident from the locked unit. No further information was provided.	F 603		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to operationalize their Resident Protection Policy and Procedure related to protecting residents from further abuse during investigation for 1 of 1 resident (R38) reviewed, who reported allegations of abuse during the survey. Findings include: Review of the facility's policy, Resident Protection	F 607	Preparation and/or execution of this report of correction does not constitute admission or agreement by the provider of the truth of the facts set forth in the statement of deficiencies required by the provisions of the federal and state law. It is the Policy of Talahi Nursing and Rehab to provide residents a safe environment that is free from harm.	4/2/18

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F 607	Continued From page 18 Policy and Procedure, revised 2/5/18, included, "Upon receiving a complaint of alleged maltreatment, the Administrator must be notified immediately and they, the Director of Nursing, or assigned designee, will coordinate an investigation, which will include completion of witness statement...When a specific staff member is implicated in the alleged event, the person will be removed from the residents care immediately, interviewed by the supervisor assigned, asked to provide a written statement and suspended until the investigation is completed...Ensuring safety and well-being for the vulnerable adult is of utmost priority." R38's annual Minimum Data Set (MDS), dated 1/18/18, identified R38 was cognitively intact, had no behaviors, and required extensive assistance of two staff for bed mobility, toileting, personal hygiene, and was totally dependent on staff for transfers and locomotion. R38's care plan, revised 1/28/18, identified R38 had chronic pain, had limited physical ability, and at times, refused to change when incontinent or when needing to change soiled clothing. Staff were directed to reapproach R38 as needed regarding compliance with cares. During an interview on 2/26/18, at 6:58 p.m. R38 stated he didn't like nursing assistant (NA)-I because she had an "attitude," and was "bossy and mean." R38 stated NA-I was physically abusive at times, because she was "so rough" and described an incident that happened earlier that day. R38 stated, "[NA-I] was trying to get me to move faster, I guess. She grabbed me on my left wrist, above the wrist, and pulled. She hurt me. I told her not to. Then she started pushing on my backside. She is so rough." R38 further	F 607	On 2/26/18 R38 reported abuse to one of the state surveyors. Upon notification to the Administrator and Director of Nursing (DON) a Vulnerable Adult was filed with OHFC and an immediate investigation was initiated. It is the Policy of Talahi Nursing and Rehab to immediately suspend individual's involved in allegations of abuse pending investigation to ensure the safety of all residents. Allegations were found to be unsubstantiated. Disposition letter has been received from OHFC. The Vulnerable Adult Protection, Abuse Policy and Procedure was reviewed ON 3/19/18 and is found to be accurate. Policy revised on 3/19/2018 to include: INDIVIDUAL MUST BE SUSPENDED PENDING INVESTIGATION. R38 was immediately assessed for safety and injury. R38 had no injuries or emotional distress. All other residents have remained safe from harm. Education for proper protocol for patient safety for abuse allegations provided to the Administrator and DON by Mordy Polstien Chief Executive Officer (CEO) of Talahi Nursing and Rehab an affiliation of Eden Senior Care. All staff have been re-educated on Vulnerable Adult reporting. A flow sheet was developed to ensure proper protocol is followed for all Vulnerable Adult reports. Audits of flow sheet will be conducted weekly for six	

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F 607	Continued From page 19 stated, "I've asked them [administration] to keep her out of my room several times. I want her out of my room." R38 indicated he had told the administrator and the social services director (SSD) several times that he didn't want NA-I caring for him, and although they both said they would talk to NA-I, nothing ever changed. R38 stated he had not reported the incident that occurred earlier that day to anyone, because, "it wouldn't make a difference." During an interview on 2/26/18, at 7:15 p.m. SSD stated, "Just today, [R38] told [administrator] that he wanted the staff to be more attentive. He doesn't feel that NA-I and NA-G are always attentive." SSD denied R38 had requested to not have NA-I care for him. When interviewed on 2/26/18, at 7:20 p.m. the administrator stated R38 "regularly complains about two of our most thorough nursing assistants," and stated he had complained last week that NA-I "just came in and looked at her phone while two others did his cares." The administrator stated she addressed R38's complaints with the director of nursing (DON) and found that NA-I doesn't carry her phone, indicating the complaint couldn't be accurate. The administrator stated R38 often complained about his care to the DON too, making "general complaints," especially about staff of color, but stated NA-I was "one of the best" NAs the facility had. The administrator denied that R38 had asked to not have NA-I care for him. At 7:30 p.m. the administrator and SSD were informed, by the surveyor, of R38's reported allegation of rough physical treatment by NA-I earlier that day. The administrator stated she would follow up.	F 607	weeks. Nursing IDT reviews Vulnerable Adult reports daily Monday through Friday to ensure a thorough investigation has been conducted and interventions are in place. The IDT/QAPI to meet monthly and evaluate outcome of these audits and determine appropriate action to follow or make recommendations. DON/Administrator/Designee is Responsible	

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During an interview on 2/27/18, at 12:09 p.m. R38 indicated NA-I was working and had delivered his breakfast tray to him that morning. R38 stated, "I just don't want her in my room."

During an observation at 2/27/18, at 2:27 p.m. NA-I was at the nurses' station, on the computer. An unidentified staff member walked up to her and asked for her assistance to transfer a resident. NA-I got up from the desk, and walked down the hallway to assist.

When interviewed on 2/27/18, at 2:51 p.m. the administrator stated, "Because we heard this from you [surveyor] and not first hand, we reported it as a VA [vulnerable adult] right away." The administrator stated the DON talked to NA-I, and SSD talked to R38. The administrator stated she wanted to hear it from R38 first, "so we did investigate a little bit first. I didn't know if we should report it or not, but I just erred on the side of caution." The administrator stated, "As far as the staff member [NA-I], we didn't do anything with her. We decided it wasn't abuse." The administrator stated R38 consistently complained about NA-I. When asked if other residents or staff were interviewed regarding NA-I, the administrator stated, "No, we aren't finished with the investigation yet. We have five days." Although the investigation was not completed, NA-I continued to work in the facility, caring for residents.

During an interview on 2/27/18, at 4:22 p.m. DON stated they were in the middle of interviewing other residents, and stated, "On other occasions, I have suspended others. I did interview the other aide in the room [during R38's cares] and she felt that it was [NA-I's] tone of voice, not physical

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F 607	Continued From page 21 rough treatment." DON stated, "It's [NA-I's] demeanor. It's natural for her. It's difficult to know if she's serious or not." When asked how the facility was providing protection to R38 and other residents while the allegation involving NA-I was being investigated, DON stated, "If I thought for one second that [NA-I] was a threat, I would certainly suspend her." Review of NA-I's time card for pay period 2/16/18 through 2/28/18, indicated NA-I worked 2/26/18 from 6:00 a.m. until 9:00 p.m., 2/27/18 from 6:00 a.m. until 9:00 p.m., and 2/28/18 from 6:00 a.m. until 10:00 a.m. Although the investigation of R38's report of alleged physical abuse was not completed, NA-I continued to work in the facility.	F 607		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey 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	F 610		4/2/18

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F 610	Continued From page 22 by: Based on interview and document review, the facility failed to ensure allegations of potential abuse were thoroughly investigated and protection provided to 1 of 1 resident (R38) who reported allegations of abuse during the survey. Findings include: During an interview on 2/26/18, at 6:58 p.m. R38 stated he didn't like nursing assistant (NA)-I because she had an "attitude," and was "bossy and mean." R38 stated NA-I was physically abusive at times, because she was "so rough" and described an incident that happened earlier that day. R38 stated, "[NA-I] was trying to get me to move faster, I guess. She grabbed me on my left wrist, above the wrist, and pulled. She hurt me. I told her not to. Then she started pushing on my backside. She is so rough." R38 further stated, "I've asked them [administration] to keep her out of my room several times. I want her out of my room." R38 indicated he had told the administrator and the social services director (SSD) several times that he didn't want NA-I caring for him, and although they both said they would talk to NA-I, nothing ever changed. R38 stated he had not reported the incident that occurred earlier that day to anyone, because, "it wouldn't make a difference." R38's annual Minimum Data Set (MDS), dated 1/18/18, indicated R38 was cognitively intact, had no behaviors, and required extensive assistance of two staff for bed mobility, toileting, and personal hygiene, and was totally dependent on staff for transfers and locomotion. R38's care plan, revised 1/28/18, identified R38 had chronic pain, had limited physical ability, and at times,	F 610	Preparation and/or execution of this report of correction does not constitute admission or agreement by the provider of the truth of the facts set forth in the statement of deficiencies required by the provisions of the federal and state law. It is the Policy of Talahi Nursing and Rehab to provide residents a safe environment that is free from harm. On 2/26/18 R38 reported abuse to one of the state surveyors. Upon notification to the Administrator and Director of Nursing (DON) a Vulnerable Adult was filed with OHFC and an immediate investigation was initiated. It is the Policy of Talahi Nursing and Rehab to immediately suspend individual's involved in allegations of abuse pending investigation to ensure the safety of all residents. Allegations were found to be unsubstantiated. Disposition letter has been received from OHFC. The Vulnerable Adult Protection, Abuse Policy and Procedure was reviewed ON 3/19/18 and is found to be accurate. Policy revised on 3/19/2018 to include: INDIVIDUAL MUST BE SUSPENDED PENDING INVESTIGATION. R38 was immediately assessed for safety and injury. R38 had no injuries or emotional distress. All other residents have remained safe from harm. Education for proper protocol for patient	

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F 610	Continued From page 23 refused to change when incontinent or when needing to change soiled clothing. Staff were directed to reapproach R38 as needed regarding compliance with cares. During an interview on 2/26/18, at 7:15 p.m. SSD stated, "Just today, [R38] told [administrator] that he wanted the staff to be more attentive. He doesn't feel that NA-I and NA-G are always attentive." SSD denied R38 had requested to not have NA-I care for him. When interviewed on 2/26/18, at 7:20 p.m. the administrator stated R38 "regularly complains about two of our most thorough nursing assistants," and stated he had complained last week that NA-I "just came in and looked at her phone while two others did his cares." The administrator stated she addressed R38's complaints with the director of nursing (DON) and found that NA-I doesn't carry her phone, indicating the complaint couldn't be accurate. The administrator stated R38 often complained about his care to the DON too, making "general complaints," especially about staff of color, but stated NA-I was "one of the best" NAs the facility had. The administrator denied that R38 had asked to not have NA-I care for him. At 7:30 p.m. the administrator and SSD were informed, by the surveyor, of R38's reported allegation of rough physical treatment by NA-I earlier that day. The administrator stated she would follow up. During an interview on 2/27/18, at 12:09 p.m. R38 indicated NA-I was working and had delivered his breakfast tray to him that morning. R38 stated, "I just don't want her in my room." During an observation at 2/27/18, at 2:27 p.m.	F 610	safety for abuse allegations provided to the Administrator and DON by Mordy Polstien Chief Executive Officer (CEO) of Talahi Nursing and Rehab an affiliation of Eden Senior Care. All staff have been re-educated on Vulnerable Adult reporting. A flow sheet was developed to ensure proper protocol is followed for all Vulnerable Adult reports. Audits of flow sheet will be conducted weekly for six weeks. Nursing IDT reviews Vulnerable Adult reports daily Monday through Friday to ensure a thorough investigation has been conducted and interventions are in place. The IDT/QAPI to meet monthly and evaluate outcome of these audits and determine appropriate action to follow or make recommendations. DON/Administrator/Designee is Responsible	

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F 610	Continued From page 24	F 610		

NA-I was at the nurses' station, on the computer. An unidentified staff member walked up to her and asked for her assistance to transfer a resident. NA-I got up from the desk, and walked down the hallway.

When interviewed on 2/27/18, at 2:51 p.m. the administrator stated, "Because we heard this from you [surveyor] and not first hand, we reported it as a VA [vulnerable adult] right away." The administrator stated the DON talked to NA-I, and SSD talked to R38. The administrator stated she wanted to hear it from R38 first, "so we did investigate a little bit first. I didn't know if we should report it or not, but I just erred on the side of caution." The administrator stated, "As far as the staff member [NA-I], we didn't do anything with her. We decided it wasn't abuse." The administrator stated R38 consistently complained about NA-I. When asked if other residents or staff were interviewed regarding NA-I, the administrator stated, "No, we aren't finished with the investigation yet. We have five days." Although the investigation was not complete, NA-I continued to work in the facility, caring for residents.

During an interview on 2/27/18, at 4:22 p.m. DON stated they were in the middle of interviewing other residents, and stated, "On other occasions, I have suspended others. I did interview the other aide in the room [during R38's cares] and she felt that it was [NA-I's] tone of voice, not physical rough treatment." DON stated, "It's [NA-I's] demeanor. It's natural for her. It's difficult to know if she's serious or not." When asked how the facility was providing protection to R38 and other residents while the allegation involving NA-I was being investigated, DON stated, "If I thought for one second that [NA-I] was a threat, I would

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F 610	Continued From page 25 certainly suspend her." Review of NA-I's time card for pay period 2/16/18 through 2/28/18, included NA-I worked 2/26/18 from 6:00 a.m. until 9:00 p.m., 2/27/18 from 6:00 a.m. until 9:00 p.m., and 2/28/18 from 6:00 a.m. until 10:00 a.m. Although the investigation was not completed, NA-I had continued to work in the facility during the investigation of R38's report of alleged physical abuse. Review of the facility's policy, Resident Protection Policy and Procedure, revised 2/5/18, included, "Upon receiving a complaint of alleged maltreatment, the Administrator must be notified immediately and they, the Director of Nursing, or assigned designee, will coordinate an investigation, which will include completion of witness statement...When a specific staff member is implicated in the alleged event, the person will be removed from the residents care immediately, interviewed by the supervisor assigned, asked to provide a written statement and suspended until the investigation is completed...Ensuring safety and well-being for the vulnerable adult is of utmost priority."	F 610		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing	F 625		4/2/18

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F 625	Continued From page 26 facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the resident or resident's representative was informed of the bed hold policy at the time of hospitalization for 1 of 2 residents (R52) reviewed for hospitalizations. Findings include: R52's admission record, dated 9/16/14, identified diagnosis including chronic pain, chronic obstructive pulmonary disease, type 2 diabetes, peripheral vascular disease, and anxiety. Review of R52's progress notes from 9/6/17 through 1/31/18, identified the following hospitalizations: -A 9/25/17 hospital leave, with a 9/27/17 return to the facility. -A 10/12/17 hospital leave, with a 10/17/17 return	F 625	Preparation and/or execution of this report of correction does not constitute admission or agreement by the provider of the truth of the facts set forth in the statement of deficiencies required by the provisions of the federal and state law. t is the policy of Talahi Nursing and Rehab to reserve a resident's bed while he/she is hospitalized or on a therapeutic leave of absence unless directed otherwise, verbally or in writing by the resident, their guardian or responsible party. The Bed Hold Policy/Therapeutic Leave Day Policy was reviewed on 3/1/2018 and found to be accurate. All licensed nursing staff and Social Services Director have been re-educated on the Bed Hold Policy and procedure for completion.	

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F 625	Continued From page 27 to the facility. -A 10/30/17 hospital leave, with a 11/3/17 return to the facility. -A 11/9/17 hospital leave, with a 11/16/17 return to the facility. -A 11/19/17 hospital leave, with a 12/13/17 return to the facility. -A 12/16/17 hospital leave, with a 12/19/17 return to the facility. -A 12/22/17 hospital leave, with a 12/28/17 return to the facility. -A 1/2/18 hospital leave, with a 1/19/18 return to the facility. Review of R52's medical record identified a Bed Hold Policy/Therapeutic Leave Day Policy, signed by R52's responsible party on 11/9/17 for hospitalization that day, and on 11/30/17, 11 days after R52 was hospitalized on 11/19/17. R52's medical record lacked any additional Bed Hold Policy/Therapeutic Leave Day Policy forms or documentation the bed hold policy was provided to R52's representative at the time of the 9/25/17, 10/12/17, 10/30/17, 12/16/17, 12/22/17, and 1/2/18 hospitalizations. The medical record also lacked documentation the Ombudsman was notified of the transfer. During an interview on 3/1/18, at 11:40 a.m. social services director (SSD) stated nursing staff had a packet that they completed when transferring a resident to the hospital and stated she helps with informing the resident or resident's representative of the bed hold policy. SSD stated the Bed Hold Policy/Therapeutic Leave Day Policy form was signed by the resident or resdient's representative and placed in the medical record, or documentation would be found in the progress notes. SSD verified R52's medical	F 625	The Social Service Director has developed a tracking form to ensure that a bed hold has been signed or verbal confirmation has been received by the resident, their guardian or responsible party. The tracking form will be audited by the IDT daily Monday through Friday. The RN Case Manager will be responsible for ensuring bed hold policy is enforced over the weekend for compliance. Education provided to all licensed staff have been re-educated on the Policy titled: Bed Hold Policy/Therapeutic Leave Day. The IDT/QAPI to meet monthly for appropriate recommendations. Social Service Director/Administrator/DON/Designee is Responsible	

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F 625	Continued From page 28 record lacked documentation that the resident or representative were provided with written information regarding the facility's bed hold policy, when she was hospitalized on 9/25/17, 10/12/17, 10/30/17, 12/16/17, 12/22/17, and 1/2/18. When interviewed on 3/1/18, at 1:32 p.m. director of nursing (DON) stated, "We do need to get a bed hold signature when a resident is hospitalized, and if not at the time, social services should obtain a signature the next day." Review of the facility's undated Bed Hold Policy/Therapeutic Leave Day Policy, included, "Residents who are transferred to a hospital will be provided with written information regarding the facilities [sic] Bed Hold Policy. If the transfer is an emergency situation, the family/responsible party will be called by nursing for decision to hold the resident's bed. Copy of the form will be sent along to the hospital for the family."	F 625		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) 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 oral cares were offered or provided for 1 of 2 residents (R55) observed, who were dependent upon staff for assistance with activities of daily living (ADLs). Findings include:	F 677	Preparation and/or execution of this report of correction does not constitute admission or agreement by the provider of the truth of the facts set forth in the statement of deficiencies required by the provisions of the federal and state law. It is the policy and procedure of Talahi	4/2/18

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F 677	Continued From page 29 R55's Admission Record, dated 1/17/17, included diagnosis of multiple sclerosis, tumor of the stomach, lung cancer, severe depression, and malnutrition. R55's quarterly Minimum Data Set (MDS), dated 2/12/18, indicated R55 had moderate cognitive impairment, felt down and hopeless, and required assistance with personal hygiene. The care plan further indicated R55 had no behavior issues and did not reject cares. In addition, the MDS identified R55 was totally dependent on staff for eating, and had a feeding tube. Review of R55's Care Area Assessment, dated 10/20/17, included R55 needed extensive assistance with ADLs, including personal hygiene, related to weakness, gastrointestinal issues, tube feeding, and limited mobility. R55's care plan, revised on 11/22/17, identified a self-care performance deficit related to fatigue and impaired balance, and required extensive assistance with personal hygiene and oral care. The care plan directed staff to, "brush teeth with extensive assist of 1," in the morning, after meals, and at bedtime. The care plan also identified R55 was totally dependent on staff for eating with tube feeding and was NPO (nothing by mouth). Review of R55's Order Summary Report, undated, included, "Nurse to ensure the resident is offered and assisted with oral cares. Use oral swabs, APPLY CHOPSTICK PRN. every shift for Oral Cares." Review of R55's Medication Administration Record (MAR) for 1/1/18-1/31/18, and 2/1/18-2/28/18 included "Nurse to ensure the resident is offered and assisted with oral cares. Use oral swabs, APPLY CHOPSTICK PRN. every	F 677	Nursing and Rehab to treat each resident with respect and dignity in an environment that promotes quality of life and individuality at all times. The DON was made aware on 3/1/18 that oral cares were not provided for R55 after an emesis. All licensed staff were immediately re-educated on the policy and procedure for providing proper oral care. R55 was immediately provided oral care. All other residents requiring extensive assist with oral cares are being provided that care as evidenced by 100% compliance by observation of cares by the RN Case Managers and review of documentation. Policy and Procedure titled Mouth/Oral Care was revised to include oral care monitoring for residents with tube feedings, NPO and extensive assist . Acute charting has been added to the MAR, and is reviewed daily by the RN Case Managers and DON, to ensure that all residents that are NPO, tube feeders or require extensive assist are receiving oral car. . All care sheets updated to reflect need for oral care. Audits will be completed for three residents three times per week for a minimum of six weeks, to ensure dignity has been provided to R55, as well as all residents residing in the facility regardless of NPO or tube feeding status. The IDT/QAPI to meet monthly to	

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F 677	Continued From page 30 shift for oral cares," with an order dated of 11/29/17. Staff have documented initials each day, at 6:00 a.m., 3:00 p.m., and 11:00 p.m. Review of the AM GROUP 3 nursing assistant care sheet, undated, identified R55 was NPO, and was to have no ice chips. There was no direction for oral cares. During an observation on 2/27/18, at 8:27 a.m. R55 was lying in bed, retching, and vomited a moderate amount of dark liquid with thick mucous, into a pink basin. R55 had no tissues in her room and used her hand to wipe away vomitus on her chin, and pushed her call light button. An unidentified female staff member came into the room, and took the basin into the bathroom to empty and clean it. The staff returned the basin to R55, raised the head of her bed, and turned off R55's tube feeding. Without offering to assist R55 with cleaning her face or oral cares, the staff left the room. When interviewed on 2/27/18, at 8:43 a.m. R55 stated, "I used to tell them I wanted to brush my teeth. They never offer. I would go into the bathroom by myself but that's a no no. They probably think I'm going to drink water or something." R55 looked down, and stated, "It used to bother me when I first came in, but I'm just used to it now." During an observation on 2/27/18, at 2:34 p.m. R55 stated she was still not feeling well. Thick, clear, stringy saliva was noted between R55's top and bottom lips as she talked and a thick white substance was noted on her top front teeth. R55 used her right hand to cover her mouth at times while she spoke. R55 stated she hadn't been	F 677	evaluate outcome of these audits and determine appropriate action to follow or make recommendations. DON/Administrator/Designee is Responsible	

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F 677	Continued From page 31	F 677		

offered oral care or brushed her teeth, but "they never do."

When interviewed on 2/28/18, at 8:14 a.m. R55 stated she was "getting rid of phlegm today," and thick clear sputum was noted in a pink basin beside her on the bed. As she spoke, R55 had a thick white substance on her teeth and at the corners of her mouth, and thick stringy saliva was noted between her lips as she talked. R55 stated she hadn't brushed her teeth "in a long time, weeks maybe months." R55 stated, "I feel like they just want me to clean myself up after I vomit, but I don't have anything to do that. They don't give me anything." R55 indicated one nursing assistant helped her brush her teeth a long time ago, and stated, "It felt so good." R55 stated, "They have told me they'll get fired if they get caught helping me brush my teeth, because I might drink water. They're told they can't give me anything. They used to occasionally give me a dry pink sponge swab. That's just gross." R55 stated she likes to go to play bingo and it used to bother her to be around other residents because her teeth weren't brushed, but stated, "I try not to let it bother me now. It's just how it is." At 9:42 a.m., R55 was observed to be dressed and sitting up in her bed. R55 stated she was given a washcloth and was able to wash her face, but wasn't offered oral cares or to brush her teeth. R55 looked down, and stated, "I'm just used to it."

During an interview on 2/28/18, at 12:24 p.m. nursing assistant (NA)-G stated he couldn't remember if he had assisted R55 with oral cares that morning because he had been running all over, but stated he would check with R55. When NA-G asked R55 if she had swabbed her mouth today, R55 stated she hadn't had oral cares in "a

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F 677	Continued From page 32 long time." NA-G stated usually the nurses do R55's oral care and that they are his boss, so if they told him to do oral cares, he would it. NA-G stated, "If she [R55] drinks water, she will throw up." When interviewed on 2/28/18, at 12:42 p.m. licensed practical nurse (LPN)-C stated there was absolutely no reason staff shouldn't be helping R55 with personal hygiene and oral cares. LPN-C indicated nurses were to document every shift that R55 had been offered and assisted with oral cares. When asked how she ensured that R55's oral cares were being done before documenting with initials on the MAR, LPN-C stated, "I just assumed that it was being done, that's part of their cares." LPN-C stated she would be reeducating the nursing assistants that they must be brushing R55's teeth. LPN-C stated, "That's awful, I just assumed that they were doing it." During an interview on 3/1/18, at 9:40 a.m. assistant director of nursing (ADON) indicated they had "triggered oral cares," for the nurses ensure R55's oral cares were being done every shift. The ADON stated R55 was "always verbalizing that she's dry," and added, "There's no problem with her doing oral cares." Review of the facility's policy and procedure, Mouth/Oral Care, revised 11/17, included, "To keep the resident's lips and oral tissues moist, cleanse and freshen the resident's mouth, and prevent infections of the mouth."	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care	F 684		4/2/18

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F 684	Continued From page 33 Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and consistently monitor skin ulcers for 1 of 1 resident (R10) reviewed for non-pressure related skin ulcer/wound. Findings include: R10's admission record dated 2/2/18, included diagnosis of Alzheimer's disease, polyneuropathy (damage or disease affecting peripheral nerves) and type 2 diabetes. R10's quarterly Minimum Data Set (MDS) dated 11/26/17, indicated R10 had severe cognitive impairment. R10's Care Area Assessment (CAA) dated 8/17/17, identified an existing pressure ulcer to unspecified site. The assessment indicated a risk for skin breakdown related to incontinence, bruising related to insulin injections, decreased mobility and immobilizer use. R10's skin was described as intact. Staff were directed to observe skin with morning and evening cares and bathing. R10's diabetic care plan initiated on 8/29/16, indicated a goal of no complications related to diabetes. The care plan directed staff to check all	F 684	Preparation and/or execution of this report of correction does not constitute admission or agreement by the provider of the truth of the facts set forth in the statement of deficiencies required by the provisions of the federal and state law. It is the policy of Talahi Nursing and Rehab to provide Quality of Care to all residents. It is the Policy of Talahi Nursing and Rehab to establish guidelines for assessing, monitoring and documenting the presence of skin breakdown, pressure and other ulcers and assuring interventions are implemented to maintain skin integrity. R10’s callous was immediately assessed by an RN and R10 was added to the wound flow sheet for weekly monitoring. All other residents with wounds are being monitored/assessed weekly by the RN Case Mangers and monthly by the AMT contract wound nurse. The policy titled: Pressure Ulcer and Skin Condition Assessment was reviewed and	

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F 684	Continued From page 34 of R10's body for breaks in skin and treat promptly as ordered by the physician, referral to podiatrist or foot care nurse to monitor and document foot care needs. The care plan further identified a potential impairment to skin integrity, initiated on 8/29/16,and revised on 2/23/18, and identified an unstageable ulcer to the left great toe related to an injury on 12/5/17. The ulcer was described as a calloused area. R10's plan of care lacked interventions to the affected left toe area for management and lacked direction to minimize further damage to toe. R10's undated nursing assistant plan of care failed to include interventions to minimize further damage to left great toe. On 12/5/17, R10's progress note indicated an open area to her left great toe measuring 2 centimeters(cm) in length and 0.5 cm wide. No pain was noted and the area was described to have been free of drainage. The note indicated R10 was independent with ambulation and wandered frequently. R10's physician and family were updated and that nursing measures for dressing change had been initiated. Staff were to continue to monitor and update physician as needed. On 12/6/17, a Physician Communication Form was completed which indicated R10 had a wound to the left great toe measuring 2 cm by 0.5 cm that was found on Monday 12/4/17. Staff indicated they were to keep area dry and apply a non stick dressing to R10's left great toe. On 12/8/17, R10's physician responded with the following order: Cleanse and dry toe every day, apply Bacitracin and cover with non stick dressing and gauze every day.	F 684	a new policy has been adapted through Pathways Health Services titled: Prevention and Treatment of Skin Breakdown. The policy was then revised to reflect RN Case Managers for East, West and North stations will be responsible to complete weekly skin/wound assessments. In addition, the policy was revised to reflect the facility's current weekly wound flow sheet of site, stage, current treatment, present condition, skin assessment completed in PCC, and physician/family notified with significant wound changes. These revisions were implemented on 3/12/18. Weekly Wound meetings were initiated with the Director of Nursing to begin on 3/30/18. A Comprehensive Pressure Ulcer Assessment Audit will be completed with weekly wound meetings to ensure that all residents' skin integrity is being maintained and free of infection. Weekly audits will be ongoing to ensure compliance. All Nursing staff have been educated on the newest policy, current wound tracking flow sheet, comprehensive Pressure Ulcer Assessment Audit and requirement for weekly wound meetings. The IDT/QAPI to meet monthly to evaluate outcome of these audits and determine appropriate action to follow or make recommendations. DON/Designee is Responsible	

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On 12/13/17, a physician progress note during routine visit indicated that R10 had an open area to left great toe measuring 1 cm by 1 cm likely due to stubbing it.

On 12/19/17, R10's progress note directed staff to cleanse and dry toe, apply Bacitracin and cover with non stick dressing and gauze, and to monitor every day.

The facility's records lacked any nursing assessments on the status of R10's skin issue from 12/6/17 thru 1/28/18.

R10's Body Audit Forms dated 12/14/17, 12/18/17, 12/27/17, 1/8/18, 1/14/18, 1/22/18, 2/5/18, 2/19/18, and 2/26/18, failed to indicate any skin alteration.

On 1/28/18, R10's progress note indicated the left great toe had a rough white callous texture with a blackened tip and that R10 was not allowing dressing changes.

On 1/31/18, a Physician Communication Form was completed which indicated R10's left great toe had a dark necrotic (the death of most or all of the cells in an organ or tissue due to disease, injury, or failure of the blood supply) tissue on left toe and also had thick calloused skin. Communication requested physician to assess and advise as R10 was a diabetic. On 1/31/18, the physician responded with the following orders: Cephalexin (an oral antibiotic) 500 milligrams (mg) twice a day for 5 days. A diagnosis of left toe cellulitis was provided and an order to have podiatry assess with next visit. Staff were directed to soak foot with warm soapy water twice a day as able until resolved then to discontinue.

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On 1/31/18, R10's physician progress note indicated cellulitis to left first digit with suspected impaired circulation contributing to callous of tip of left great toe. Physician indicated area appeared to need debridement (the medical removal of dead, damaged, or infected tissue to improve the healing potential of the remaining healthy tissue) and to have R10 see house podiatrist. Staff directed to provide R10 with 5 day course of Cephalexin and to do foot soaks twice a day as able due to dementia level.

On 2/2/18, R10 was seen by a podiatrist. The podiatry report indicated that R10 had a history of peripheral vascular disease (a condition of the blood vessels that supply the legs and feet. It leads to narrowing and hardening of the arteries. This causes decreased blood flow, which can injure nerves and other tissues) and was seen for the evaluation and care of pressure related hyperkaratosis formation (thickening of the outer layer of the skin, often part of the skin's normal protection against rubbing, pressure and other forms of local irritation). Mechanic debridement of calloused skin lesion to tip of left toe was conducted.

On 2/5/18, R10's progress note indicated that R10 would not sit long enough to soak feet, no black tissue, drainage, odor or pain reported.

On 2/7/18, R10's progress note indicated treatment to left great toe was done and there was a small amount of red drainage from toe.

On 2/8/18, R10's progress note indicated R10's left great toe area was scabbed and surrounding skin was dry, no open areas, drainage or redness

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or signs of infection noted.

On 2/9/18, R10's progress note directed staff to provide lower body bath to ensure foot soak treatment.

On 2/9/18, R10's progress note indicated R10 would not sit long enough for foot soak.

On 2/9/18, R10's progress note indicated R10's left great toe wound was currently unstagable due to dried callous. R10's wound measured 2.2 cm X 0.6 cm with no drainage or odor. Wound was described as a dry calloused area with slit in middle of callous. Dried blood was present to the area of slit. No darkened areas present at that time.

On 2/11/18, R10's progress note indicated staff were unable to conduct treatment to left great toe as R10 was up and walking.

On 2/13/18, R10's progress note indicated thick calloused skin at end of toe with no necrotic tissue, drainage, bleeding or pain noted.

On 2/15/18, R10's progress note indicated left great toe wound was unstageable and measured 2 cm by 2.5 cm. Wound is described to appear as a callous with a slit in the middle of it with dried blood to area of slit. No dark areas were noted.

On 2/19/18, a Physician Communication Form was completed and indicated staff were having a hard time soaking foot and covering left great toe. R10 was reported to try to get up and would not stay still for treatment. R10's left great toe was reported to be calloused with small dark spot on tip. The physician responded on 2/21/18, and

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ordered to have podiatry assess on their next in house visit and to discontinue foot soaks and continue to monitor.

On 2/19/18, R10 was seen by podiatrist. R10 received a general foot exam and evaluation and determined to be eligible for continued care and consultation. The consultation of 2/19/18, did not address a plan for the affected area on left great toe.

On 2/20/18, a Physician Communication Form was completed and indicated R10 had a pressure injury to left great toe, she needed prompts to stay seated for meals and needed more protein for wound healing. A request for Prosource (a protein supplement) every day was submitted. Physician responded on 2/21/18, with an order for Prosource every day.

On 2/22/18, R10's progress note indicated left great toe was unstagable and measured 1.2 cm by 2.4 cm..

During interview on 2/28/18, at 8:08 a.m. registered nurse (RN-E) stated wounds were to be assessed by facility's wound nurse once a week with weekly rounds and that documentation was to placed into the resident's progress notes.

On 2/28/18 at 12:07 p.m. RN-E stated there were no weekly documentation notes consistently in the record when R10 developed the skin issue on 12/5/17, to the left toe. RN-E stated that they had poor documentation during that time. RN-E stated that they noticed the necrotic area on 1/31/18, and updated the physician who prescribed an antibiotic. RN-E stated they also had podiatry evaluate R10's wound. RN-E stated

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that originally the order on 12/6/17, included to have wound monitored and that meant a progress note was to be placed in R10's progress note record. RN-E verified that R10 did not have a care plan with interventions in place for the reduction of risk for deterioration to left great toe wound. RN-E also verified there was no comprehensive assessment of R10's wound upon onset, prior to or at the time of the interview that included identified risks and interventions to minimize or prevent continued skin deterioration. RN-E stated that the blue canvas shoes R10 wore had not been assessed for proper fit or appropriateness and had not been considered a factor in wound healing promotion.

During observation of wound dressing on 2/28/18, at 1:10 p.m. LPN-B removed blue canvas shoe and dressing dated 2/27. The left great toe had a non stick bandage secured by kerlix. The non stick bandage had a circular area of 0.5 cm of dark brown drainage. The left toe had a scabbed yellow area of 2 cm immediately following a dark area of 1.5 cm surrounding the yellow area located at the tip of the toe. A 0.5 cm open area was present in the middle of the dark area, presenting at the tip of the toe. LPN- B was uncertain if the wound could be pressure related.

On 3/01/18, at 8:27 a.m. LPN-B checked left foot toe placement again. R10 was wearing a pair of white leather sneakers. The foot placement in the white sneaker was verified to be better with very little curling of the toes observed. LPN-E stated when the white shoes were provided on 2/28/18, the toes were not curled and she wondered if the bandage played a part on the way R10's toe was curled. LPN-B stated she would call podiatry for direction and update the family.

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F 684	Continued From page 40 During interview on 3/01/18, at 11:22 a.m. the DON stated that the facility did not have a wound nurse during the time the wound was first noted on 12/5/17, and the system failed due to not having a "to go" person for the evaluation of wounds. The DON stated she would have expected weekly assessments on wounds with measurements. The facility's undated policy titled, Pressure Ulcer and Skin Assessment Policy, indicated that pressure ulcers and other ulcers including diabetic, arterials and venous would be assessed and measured at least every seven days by a licensed nurse and recorded on the facility approved Wound Assessment Form. Ongoing weekly measurements would reflect the healing process, wound appearance, size and depth.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	F 686		4/2/18

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F 686	Continued From page 41 Based on observation, interview and document review, the facility failed to comprehensively assess the effects on the skin when using a pommel cushion for 1 of 2 residents (R30) reviewed for pressure ulcer care and who developed an open area after one was implemented. Findings include: R30's quarterly Minimum Data Set (MDS) dated 12/19/18, indicated R30 had severe cognitive impairment, required extensive assistance for transfers, and limited assistance with locomotion on and off the unit. The MDS indicated R30 was at risk for pressure ulcer development, had no current pressure ulcer(s) or other skin lesions/wounds, and did not use any pressure reducing device(s) on her chair or bed. R30's most recent Tissue Tolerance (tool used to measure ability of skin to resist pressure without adverse effect) dated 2/9/18, indicated R30 could tolerate a two hour reposition schedule in bed and "in a chair." The completed tool lacked any information on what, if any, type of cushion R30 used in her wheelchair when the observation was completed. R30's care plan dated 1/7/18, identified a potential for impaired skin integrity due to fragile skin and urinary incontinence. A goal was listed to, " ... maintain or develop clean and intact skin by the review date," and several interventions were associated to help R30 meet this goal including educating R30 on causative factors and measures to prevent skin injuries, providing good nutrition and, "Identify/document potential causative factors and eliminate/resolve where	F 686	Preparation and/or execution of this report of correction does not constitute admission or agreement by the provider of the truth of the facts set forth in the statement of deficiencies required by the provisions of the federal and state law. It is the Policy of Talahi Nursing and Rehab to establish guidelines for assessing, monitoring and documenting the presence of skin breakdown, pressure and other ulcers and assuring interventions are implemented to maintain skin integrity. The pommel cushion for R30 was removed to ensure skin integrity. R30□s skin assessment was completed on 2/28/18 with no open area to coccyx, and again on 3/16/18 with no pink area or open area. Hospice orders were obtained due to change in condition. Resident was assessed by hospice and provided a broda chair for better positioning. R30□s skin integrity is intact. The policy titled: Pressure Ulcer and Skin Condition Assessment was reviewed and a new policy has been adapted through Pathways Health Services titled: Prevention and Treatment of Skin Breakdown. The policy was then revised to reflect RN Case Managers for East, West and North stations will be responsible to complete weekly skin/wound assessments. In addition, the policy was revised to reflect the facility□s current weekly wound flow sheet of site, stage, current treatment, present	

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F 686	Continued From page 42 possible." The care plan further indicated R30 was provided a pommel cushion in her wheelchair on 2/22/18, to provide good positioning related to a sustained fall. During observation on 2/26/18, at 12:05 p.m. R30 was assisted out of the dining room in a standard wheelchair. R30 was seated on a black colored, pommel style cushion (thick cushion with a visible, raised center portion designed to reduce sliding forward in the wheelchair). R30's feet were flat on the floor and she was seated upright with no leaning or slouching. R30's Progress Note dated 2/26/18, identified an "open area to coccyx," which measured 1.0 centimeters (cm) by 0.2 cm in size. The note lacked any identified staging of the wound, however, recorded it as having no drainage or associated pain for R30. R30's medical record was reviewed and lacked evidence her skin or risk factors had been comprehensively assessed to ensure she could tolerate the new pommel cushion in her wheelchair since implementation on 2/22/18. On 2/28/18, at 7:52 a.m. R30's morning care was observed. Nursing assistant (NA)-E and NA-F assisted R30 to turn onto her left side in bed exposing her buttocks and coccyx. R30 had a tan colored foam dressing in place on the top of her gluteal crease. Registered nurse (RN)-E entered the room and removed the dressing revealing a visible, pink colored creased portion of skin on R30's coccyx immediately above her gluteal crease. RN-E described the area as measuring 2 centimeters (cm) by 1 cm and stated the area "didn't really look open, just pink." RN-E	F 686	condition, skin assessment completed in PCC, and physician/family notified with significant wound changes. These revisions were implemented on 3/12/18. Weekly Wound meetings were initiated with the Director of Nursing to begin on 3/30/18. A Comprehensive Pressure Ulcer Assessment Audit will be completed with weekly wound meetings to ensure that all residents□ skin integrity is being maintained and free of infection. Weekly audits will be ongoing to ensure compliance. All Nursing staff have been educated on the newest policy, current wound tracking flow sheet, comprehensive Pressure Ulcer Assessment Audit and requirement for weekly wound meetings. The IDT/QAPI to meet Monthly to evaluate outcome of these audits and determine appropriate action to follow or make recommendations. DON/Designee is Responsible	

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added she had never seen the wound before and did not recall ever hearing it had been open.

When interviewed on 2/28/18, at 8:41 a.m. NA-E stated she had noticed an open area on R30's coccyx earlier in the week which looked "redder" then versus when seen by the surveyor on 2/28/18. NA-E stated she had observed R30 using the pommel cushion in her wheelchair for "about two weeks," and had noticed she leaned to the side at times, especially if she falls asleep. Further, NA-E explained she was unaware how R30 developed an open area to her bottom.

During interview on 2/28/18, at 8:49 a.m. licensed practical nurse (LPN)-B stated R30's pommel cushion was placed by therapy due to a recent fall and stated R30 would "sometimes" be found slouching or leaning in the chair. LPN-B was unaware how R30 had obtained an open area to her coccyx and added she was "not exactly sure" on how pressure ulcer risk was assessed when using new cushions and medical positioning devices in wheelchairs. Further, LPN-B added she did not believe R30's skin had been assessed to tolerate the newly placed cushion.

When interviewed on 2/28/18, at 12:31 p.m. RN-E stated she managed R30's care since July 2017. She stated R30 had sustained several falls and was "very unsteady" with her ambulation. RN-E explained R30 sustained a fall from her wheelchair and the pommel cushion was placed on 2/22/18. RN-E reviewed R30's medical record and stated R30 had not been reassessed for her pressure ulcer risk after having a the pommel cushion placed and should have been as she could have developed the skin breakdown as a result. RN-E stated R30 had only recently started

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F 686	Continued From page 44 using a wheelchair for her mobility and added R30's skin was, "already weak and fragile." A facility Policy and Procedure for the Prevention and Treatment of Skin Breakdown revised 8/2011, identified it was the policy of Volunteers of America to " ... properly identify and assess residents whose clinical conditions increase the risk for impaired skin integrity, and pressure ulcers; to implement preventative measures; and to provide appropriate treatment modalities for wounds according to industry standards of care." The policy directed a Braden Scale (assessment used to determine pressure ulcer risk) and Skin Risk Data Collection would be completed on admission, weekly for the first four weeks after admission, quarterly and "with a change in status," which included changes in mobility, continence and changes in condition.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with	F 688		4/2/18

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F 688	Continued From page 45 the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow care planned interventions to maintain or improve range of motion for 1 of 3 residents (R33) reviewed for range of motion. Findings include: R33's admission Minimum Data Set (MDS) dated 12/1/17, indicated intact cognition, refused care 4-6 out of 7 days, and was verbally abusive to others which significantly impacted care. Further, the MDS indicated R33 required extensive assistance from staff with most ADL's and had a functional limitation in range of motion of one upper extremity. R33's face sheet indicated recent neck surgery and an intellectual disability. R33's care plan dated 12/8/17 included, "The resident has limited physical mobility r/t [related to] weakness to extremities and decreased motion of her L [left] arm d/t [due to] cervical [neck]." The care plan goal included, "The resident will remain free of complications related to immobility, including contractures, thrombus [blood clot] formation, skin break-breakdown, fall related injury through the next review date." A care plan intervention was added on 2/3/18, "Nursing Rehab/Restorative: Passive ROM [range of motion] Program #1 ROM to L upper extremity 10 repetitions 2 times per day. Passive ROM to bilateral lower extremities 10 repetitions 2 times per day." The care plan did not address a left hand splint.	F 688	Preparation and/or execution of this report of correction does not constitute admission or agreement by the provider of the truth of the facts set forth in the statement of deficiencies required by the provisions of the federal and state law. It is the policy of Talahi Nursing and Rehab to ensure that all residents on a Range of Motion Program receive treatment to increase range of motion or prevent further decrease in range of motion. The Policy and Procedure titled: Range of Motion was reviewed and has been modified to include a Responsibility category: The MDS Coordinator will receive the range of motion recommendations. The MDS Coordinator will care plan the recommendations and link is to the Plan of Care (POC) in Point Click Care (PCC) and track daily for compliance. R33 was provided range of motion and staff were immediately re-educated to chart appropriate minutes spent and not zero. All other residents with range of motion/walking programs have been assessed and are receiving services and charting is accurate. Staff assignments have been modified to include a Bath/Rehab aide to ensure that	

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F 688	Continued From page 46 When interviewed on 2/26/18, at 1:40 p.m. R33 stated she used to receive physical therapy (PT) and occupation therapy (OT). Then stated she is supposed to receive ROM to her left arm and both her legs, but that no staff ever do it for her. R33 was observed to be wearing a splint on her left wrist. R33 stated staff do not remove the splint for cares or ROM, and that she has had the splint since admission. When interviewed on 2/27/18, at 8:13 a.m. R33 was up and dressed for the day and stated she did not receive any PROM last evening or this morning with cares. During observation on 2/28/18, at 8:37 a.m. staff were finishing up morning cares, no PROM was observed during cares. R33 stated she did not receive PROM at all yesterday or this morning. When interviewed on 2/2/18, at 8:15 a.m. nursing assistant (NA)-C stated she was not aware of any PROM program for R33 and had not completed PROM this morning. NA-C showed an, "AM Group 3" worksheet which listed resident care needs, no PROM instructions were on this worksheet. When interviewed on 2/27/18, at 2:01 p.m. physical therapist (PT)-C stated R33 had received physical therapy, when R33 did not progress, physical therapy was discontinued and a restorative nursing program for PROM was given to nursing to do PROM to both legs. When interviewed on 2/27/18, at 2:05 p.m. occupational therapist (OT)-D stated R33 used to receive occupational therapy and when done a recommendation to nursing was provided for PROM to left arm.	F 688	R33 and all other residents are receiving their range of motion/walking program as evidenced by 100% compliance signed by and RN daily. A daily audit tracking flow sheet has been created and implemented to ensure that all residents with a Range of Motion/Walking Program have been care planned, linked to POC and charted on. Refusals will be followed up by the MDS Coordinator daily to ensure compliance for all residents. Audits will be ongoing. All Nursing staff have been re-educated on proper Range of Motion Programming and documentation. The IDT/QAPI to meet monthly to evaluate outcome of these audits and determine appropriate action to follow or make recommendations. MDS Coordinator/DON/Designee is Responsible	

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During observation on 3/1/18, at 8:08 a.m. nursing assistant NA-A was just finishing up PROM exercises with R33. NA-A stated she always does PROM on left hand and both legs when she works with her and was not aware of R33 ever refusing the care planned PROM.

When interviewed on 2/28/18, at 7:36 a.m. registered nurse (RN)-B stated R33 receives PROM twice a day, the time of day may vary. RN-B was aware R33 wore a splint on her left wrist, but did not find any instructions or care planning related to the splint. RN-B stated R33 directed when she wished to have it on or off.

When interviewed on 3/1/18, at 9:10 a.m. RN-A stated she was unaware of any PROM program for R33.

R33's Nursing Rehab/Restorative: Passive ROM Program documentation directed staff to perform the PROM twice a day with instructions identical to those in the care plan. However, the PROM was only documented as being completed 16 out of the 46 opportunities, at twice a day, between the care plan start date of 2/3/18 to 2/27/18. The rest of the documentation showed, "0." There was no explanation on the documentation as to what the "0" meant, such as resident refusal, or staff didn't perform the PROM for some other reason.

When interviewed on 3/1/18, at 1:39 p.m. NA-B reviewed the Passive ROM Program documentation and stated the aides would document zero's if the resident refused or they did not get it done. NA-B stated R33 refused cares frequently. She would report to a nurse any

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F 688	Continued From page 48 refusal by the resident. When interviewed on 3/1/18, at 10:37 a.m. RN-D stated the "0" would mean the PROM didn't get done, if the resident refuses, the nursing assistant should report this to a nurse for documentation. If they do not, there is no way to determine if the "0" meant the resident refused or staff did not offer. No evaluation of R33's PROM program had been done to determine why it was not being consistently performed. Therefore, no counseling had been provided to the R33 about the risks of refusal of the PROM program and no other interventions/alternatives had been placed to maintain ROM for R33's left upper extremity or legs. The OT and PT recommendation to start the PROM program was requested, but not provided. A hand written note received on 3/1/18, at 1:44 p.m. indicated therapy had not made a recommendation to nursing for the PROM, that it was a nursing order. When interviewed at 3/1/18, at 2:07 p.m. PT-C and OT-D indicated they had given the PROM recommendation to nursing, but were unable to locate it. A facility policy Range of Motion, dated 8/1/15 did not identify steps to ensure PROM was being completed as care planned or how the program would be monitored or evaluated.	F 688		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes,	F 692		4/2/18

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F 692	Continued From page 49 both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. 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 address unplanned weight gain for 1 of 1 residents (R13) who sustained an undesired weight gain of over 20 pounds in the past six months. Findings include: R13's quarterly Minimum Data Set (MDS) dated 11/27/17, identified R13 had intact cognition and required supervision with eating. R13's height was recorded at 62 inches, and her weight was recorded at 163 pounds (lbs). R13 had no weight gain or weight loss recorded. In addition, R13's Order Summary Report printed 3/1/18, indicated R13 had no current order(s) for any medications with known and/or common side	F 692	Preparation and/or execution of this report of correction does not constitute admission or agreement by the provider of the truth of the facts set forth in the statement of deficiencies required by the provisions of the federal and state law. It is the Policy of Talahi Nursing and Rehab to ensure that all residents will have a standardized nutrition plan and will receive necessary nutrition. R13's physician has been notified regarding resident's weight gain with the following response " Could consider discontinuing double portion meats, not concerned about weight gain though-Grace appears well nourished and	

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F 692	Continued From page 50 effect(s) for weight gain. R13's nutritional care plan dated 12/5/17, identified a potential for altered nutrition related to consuming a modified diabetic diet. A goal was listed which described, "[R13] will maintain adequate nutritional status as evidenced by maintaining weight within 5% of 160# [pounds]...," and interventions listed including explaining and reinforcing the importance of the ordered diet, monitoring and reporting any trouble swallowing and monitoring and recording signs of malnutrition. The care plan lacked any dictation regarding R13's preferences for her weight. During interview on 2/26/18, at 4:20 p.m. R13 stated she had gained weight from inactivity while living at the nursing home as "[I] just sit here all the time." R13 expressed she did not want to gain weight, in fact, wanted to lose weight as she was running out of clothes which fit her and needing to get "bigger ones." R13 explained she had never been asked about her weight gain, but did not report her concerns either as she was concerned they would then "do the opposite." On 2/28/18, at 8:39 a.m. R13 was seated in the dining room eating breakfast independently. R13 had been served a bowl of dry cereal, a single buttered piece of toast and scrambled eggs mixed with diced ham. R13 stated she had "two toast going on three," now. R13 consumed 100% of the provided meal. R13's Weights and Vital Summary report printed 3/1/18, identified the following weights recorded for R13: 02/09/18 - 185.8 lbs, 01/16/18 - 173.8 lbs and,	F 692	medically stable". All other residents weights have been reviewed by the Dietician with recommendations provided to notify the physician for significant loss, gain or need for nutritional supplements for wound healing The Policy and Procedure titled: Nutrition has been reviewed and revised to weigh all residents on a weekly basis to ensure proper monitoring of all residents weight gain or loss. The Certified Dietary Manager will monitor the weekly weights and update nursing with significant gain, loss or need for nutritional supplements. Monthly Dietician contracted with Nutritious Lifestyles will monitor bi-weekly for weight gain, loss or need for nutritional supplements to increase wound healing, with updates provided to Nursing for notification of Physician with significant changes. All staff re-educated on Policy titled: Nutrition The IDT/QAPI to meet in one month for appropriate recommendations. Dietary Manager/DON/Designee is Responsible	

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F 692	Continued From page 51 11/15/17 - 163.0 lbs. R13's last completed Nutrition Progress Note dated 12/6/17, indicated a Body Mass Index (BMI) of 29.8 and a modified diabetic diet. An Ideal Body Weight (IBW) of 118-132 lbs was identified for R13. R13 consumed 100% of most provided meals and "will request more of some items that she likes such as fish and meats." No dietary supplement(s) were provided and her current weight was recorded at 163 lbs. In addition, a section labeled, "Weight Trend," identified R13 had a, "7% weight gain in past 6 months, suspect meal intake was poor prior to admit to facility. Weight has stabilized at 162-165# range." R13's medical record was reviewed and lacked any evidence R13's continued weight gain had been comprehensively assessed including addressing medications being consumed which could exacerbate weight gain/loss, her activity involvement and energy being spent as a result, or any evidence R13 had been consulted in her weight gain and afforded participation in her care planning regarding such. When interviewed on 3/1/18, at 9:35 a.m. nursing assistant (NA)-E stated R13 ate well and "cleans her plate." R13 is served double portions of meat, stemming from a care conference she had prior, and did not like to waste food as she lived in an environment prior which "nothing ever went to waste." NA-E explained she was unaware of R13's current weight, or if she had any recent weight gain or loss, as the bath aide records those results. During interview on 3/1/18, at 11:30 a.m.	F 692		

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registered nurse (RN)-E stated R13 was served double portions of meat as she had been requesting to have more food at meals. RN-E acknowledged R13 had "been gaining some weight," and explained R13 had no heart failure or edema related concerns which could be contributing to the weight gain. RN-E stated she was unaware if R13's continued weight gain had been addressed or assessed. Further, RN-E explained they should talk to R13 about the "benefits and risks" of weight gain as it could lead to "other issues," if it was left unchecked.

When interviewed on 3/1/18, at 12:47 p.m. the certified dietary manager (CDM) stated R13 had a good appetite and enjoyed large portions at meals. CDM expressed she was aware R13 had gained weight and credited much of it to R13's improved intake, as prior to admission R13 was feeding cats and not eating well herself. CDM reviewed R13's recorded weights in the medical record and stated she "didn't even see that one" recorded on 2/9/18 (185.5 lbs), so R13's continued weight gain had not been addressed, assessed or referred to the registered dietician (RD) for counseling or input. CDM questioned if the weight recorded was accurate, so a series of collected weight(s) in the bath aide book were reviewed with the surveyor. R13's weight was last taken on 2/21/18 (8 days prior), and recorded as 183.5 lbs which would be considered "significant" weight gain for R13.

A facility Nutrition policy reviewed 9/2015, identified residents will receive necessary nutrition and listed a procedure which included, "Dietary consult as needed," and, "Notify MD and family for significant weight change and place resident on a weekly weight monitoring."

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F 755 SS=F	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. 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. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure emergency medications were readily available and not expired in 1 of 2 emergency kit(s) observed. This	F 755	Preparation and/or execution of this report of correction does not constitute admission or agreement by the provider of the truth of the facts set forth in the	4/2/18

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had potential to affect all of the 73 residents residing in the facility who could have required these medications on an emergent basis. In addition, the facility failed to develop and implement policies and procedures to ensure the safe disposition of used transdermal narcotic patches which had potential to affect 3 of 3 residents (R4, R56, R64) who had active orders for these patches in the facility. Further, the facility failed to ensure physician orders were reconciled and transcribed accurately to prevent potential medication errors for 2 of 7 residents (R272, R26) observed to receive medication during the survey.

Findings include:

EMERGENCY KIT MEDICATIONS:

On 2/27/18, at 10:07 a.m. the "North" medication room was toured with registered nurse (RN)-A. During this time, licensed practical nurse (LPN)-C opened the door and removed a tackle-box type emergency kit from the cupboard; opening and removing medications from it. The outside of the kit had a visible, green colored card labeled, "Expired E-Kit Meds Oral/Inj," with a handwritten date of, "9/17." The contents of the kit were reviewed with RN-A and the following expired medications were identified:

- Six Prednisone (a steroid medication) 5 mg (milligram) doses, each expired 12/17/17;
- Six Warfarin (a blood thinner) 2 mg doses, each expired 12/17/17;
- Six Nitrofurantoin Mono-Macro (an antibiotic) 100 mg doses, each expired 11/25/17;
- Four Amoxicillin (an antibiotic) 250 mg doses, each expired 11/30/17;

statement of deficiencies required by the provisions of the federal and state law.

It is the Policy of Talahi nursing and Rehab to provide all residents with emergency medications, safe medication disposal and prevention of potential medication errors.

The DON and Administrator were notified that the emergency kit located in the North Medication room contained multiple expired medications. The DON and Administrator had the emergency kit immediately removed by a pharmacy representative from Omni Care. A thorough investigation as to which residents may have received expired medications was completed. The Physician was notified with no new orders or concerns noted. No residents were adversely affected. The facility will continue to maintain only one emergency kit. The DON and Pharmacy consultant will meet monthly for emergency kit reconciliation to ensure no medications are expired.

It is the responsibility of the pharmacy in conjunction with the facility to provide reconciliation of medications in all facility emergency kits to ensure medication expirations dates and replacement of medications. The Pharmacy is responsible to provide the DON with proper monthly emergency kit report. That has been provided for only one emergency kit. Omni Care has provide the facility with a list of medications in the

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F 755	Continued From page 55 - One Augmentin (an antibiotic) 875/125 mg dose, expired 5/18/17; - One Augmentin 875/125 mg dose, expired 2/9/18; - Four Augmentin 875/125 mg doses, expired 1/19/17; - Two Augmentin 25-125 mg doses, each expired 11/30/17; - Six Ciprofloxacin (an antibiotic) 250 mg doses, each expired 10/28/17; - Six Levofloxacin (an antibiotic) 250 mg doses; four doses expired 12/20/17, and two doses expired 10/21/17; - Six Metronidzaole (an antibiotic) 250 mg doses; five doses expired 2/13/18, and one dose expired 9/29/17; - Four unopened ampules of Lasix (a diuretic) 20 mg (10 mg / milliliter [ml]), each dose expired 10/10/17; - Two unopened ampules of Vitamin K (a clotting agent) 10 mg/ml, each dose expired 10/1/17; - Two unopened vials of Naloxone (treats narcotic overdose) 0.4 mg/ml, each dose expired 11/1/17, and; - Six doses of Potassium Chloride (metal salt supplement) 10 MeQ (milliequivalents), each dose expired 11/2017. Further, the kit contained four separate white pharmacy slip(s) which identified medications had been removed from the kit four times since December 2017; one of the removed medications being identified as expired when used. When interviewed immediately following this review, RN-A verified these findings and stated the pharmacy was responsible to monitor and change-out these emergency kits. The night shift also was responsible to "look at them" while doing	F 755	existing emergency kit. Implementation of the Omnicare policy titled: Emergency Medication supplies. All licensed nursing staff have been provided education on the Policy titled: Emergency Medication Supplies. It is the policy of Talahi Nursing and Rehab to ensure proper disposal of all medications. The Policy titled: Safe Disposal of Used Fentanyl Transdermal Patches was reviewed and modified according to the Food and Drug Administration manufacturer instructions to discard the patch in the toilet and flush for disposal. No residents or staff were affected by improper disposal. All licensed staff have been provided education on the proper disposal and reconciliation of Fentanyl Transdermal Patches to ensure safety for residents and staff at all times. It is the policy of Talahi Nursing and Rehab to prevent the potential for possible medication errors. A policy was developed titled: Transcription of Orders to ensure proper transcription and administration of medications. R272's and R26's orders was immediately clarified with specific instructions provided in the MAR for proper application of the Lidoderm Patch, along with R26's eye drops to reflect one drop to each eye as	

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F 755	Continued From page 56 their assigned cleaning tasks. RN-A stated she would notify the pharmacy of the expired medications. RN-A explained it was important to ensure non-expired medications were available in emergency kit(s) for "appropriate treatment of the resident" adding "all the residents" could be affected or need these medications on an emergent basis. During interview on 2/27/18, at 3:16 p.m. the director of nursing (DON) stated she was unaware the facility had that emergency kit available as she, "thought there was only one." The pharmacy was responsible to review these kit(s) and ensure they were not expired, as giving expired medications to a resident "could be detrimental to someone's health." An undated Emergency Drug Kit policy identified a purpose to provide medications in emergencies and listed a procedure including verification of expiration date(s) of removed medications. The policy directed, "Notify pharmacy if drug is outdated," however, but lacked information or direction on how to monitor the kit(s) to ensure medications were not allowed to expire. TRANSDERMAL PATCHES: An undated, facility provided Fentanyl Patche listing identified R4, R56 and R64 resided in the facility and had current physician order(s) for Fentanyl (a narcotic medication) transdermal patches. A facility Safe Disposal of Used Fentanyl Transdermal Patches policy dated 2/26/18, indicated disposal methods for controlled	F 755	ordered. All other residents with orders for patches and eye drops were reviewed to ensure accuracy. An audit tool has been developed and implemented for three residents three times a week for six weeks to ensure proper transcription of orders. The Health Unit Coordinator (HUC) and all licensed Nursing staff have been provided education on new policy. The IDT/QAPI to meet monthly to evaluate outcome of these audits and determine appropriate action to follow or make recommendations. DON/Pharmacy Services/Designee is Responsible	

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medications, "must involve a safe and secure method to prevent diversion and/or accidental exposure." The policy listed three steps to complete this action including documenting the removal of used patches on the medical record, using gloves when removing the patches and, direction to "Discard the patch in an appropriate sharps container."

On 2/26/18, at 11:50 a.m. the "North" medication cart was reviewed with licensed practical nurse (LPN)-A. A locked narcotic cabinet was opened. The cabinet contained several oral narcotic medications along with an opened box of Fentanyl transdermal patches. LPN-A explained the process for changing these patches and stated the used patches were removed in the presence of two nurses, and flushed down the sewer.

On 2/26/18, at 12:13 p.m. the "Rosewood" medication cart was reviewed with LPN-B. Again, a locked narcotic cabinet was opened which contained Fentanyl transdermal patches. LPN-B stated she changed patches without other nurses present. She stated she would just "stick 'em in the sharps container," affixed to the medication cart. The sharps container was attached to the cart inside a tan colored, keyed box, however, LPN-B explained the nurses had key(s) to open these and access the sharps container(s) as desired. LPN-B stated she had asked about the process to change Fentanyl patches when she started, however, the person orientating her did not know. She stated the preceptor was going to find out but never came back with the information.

During interview on 2/28/18, at 2:18 p.m. the

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consulting pharmacist (CP) stated the facility was provided a policy for transdermal narcotic patch destruction and the process was "supposed to be" having two nurses witness the removal of the used patch and then flushing it down the sewer. CP explained this procedure was both a pharmacy recommendation along with a standard of practice adding "they should not go in the sharps container," as the used patches can still contain narcotic medication. Further, CP stated she did not recall being involved with the creation of the facility's current policies and procedures.

An Omnicare (the facility pharmacy vendor) Patient Safety Alert dated 12/2017, identified the Centers for Medicare and Medicaid (CMS) has addressed the safe disposal of used transdermal patches and described a "Mega Rule." This identified transdermal patches are a "unique situation" due to multiple box warnings being listed along with "the substantial amount of Fentanyl [sic] remaining in the patch after removal, creating a potential for abuse, misuse, diversion, or accidental exposure." The Food and Drug Administration (FDA) and manufacturer instructions recommend users remove the patch and dispose of them by folding them in half and "flushing the patch down the sink or toilet, due to the life threatening risk associated with exposure to or ingestion of the patch." The alert directed facilities should be documenting the removal of these patches in the record, and listed directions, "If not flushing the used patch, assure it is secured and inaccessible to staff, residents, or visitors until it is disposed."

When interviewed on 3/1/18, at 2:50 p.m. the director of nursing (DON) stated the facility had pharmacy recommendations for narcotic

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transdermal patch destruction, however, did not have a formal policy in place when the survey started. The DON stated the facility had never collaborated with the pharmacist to develop a policy, so they were just using the guidelines provided.

ORDER RECONCILIATION:

On 2/26/18, at 7:15 p.m. licensed practical nurse (LPN)-D prepared medications for R272 at a cart in the hallway on the "West" unit. LPN-D had a single 5% Lidoderm patch (applied directly to the skin and used for localized pain) cut in half on the medication cart and provided the labeled packaging to the surveyor for review. The directions listed to apply two patches daily, "on for 12 HRS [hours] and off for 12 HRS." LPN-D brought the cut up, single Lidoderm patch into R272's room and exposed her back to apply it. There were no patches on R272's back, and R272 stated they "both fell off," earlier in the day. LPN-D applied one piece of the cut up patch to both shoulder blade(s) and returned to the cart.

R272's hospital Orders Discharge Report dated 2/19/18, identified an order for a two Lidoderm 5% patches to be applied "daily." R272's Order Summary Report (facility transcribed orders) signed 2/21/18, identified an order for Lidoderm 5% patch to be applied "topically two times a day" for pain. The order had direction on the bottom to, "Apply 2 patches."

R272's medical record was reviewed and lacked any evidence these conflicting orders were clarified with R272's physician to ensure the medicated patches were being applied in

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accordance with the physician's intent.

When interviewed on 2/26/18, at 7:29 p.m. LPN-D stated she cut(s) the single patch in half and "would assume" it was still considered to be the same dose. LPN-D reviewed R272's medical record and stated her original hospital orders (dated 2/19/18) and her transcribed orders (dated 2/21/18) did not match, nor did her most recent order match the manufacturer instructions for correct application. LPN-D stated the orders were conflicting and should have been clarified to ensure the correct dosing was being applied adding, "it wasn't caught on our side." LPN-D explained it was important to ensure orders are clarified and correct, as not doing so could constitute a medication error.

On 2/28/18, at 8:13 a.m. LPN-A prepared medications for R26 outside his room. LPN-A removed a bottle of opened Prednisone Acetate 1% ophthalmic drops from the cart. These were labeled with instructions to, "Instill drop(s) into eyes four times daily for 14 days." The label lacked any indication on how many drops should be applied. LPN-A entered R26's room and proceeded to administer two drops of the medicated solution into each eye of his eyes. R26 did not voice any preferences for his drop(s) as they were administered. When interviewed immediately following, LPN-A stated she administered two drops in each eye as R26 "be requesting two." LPN-A stated she thought if she only administered one drop to each eye, R26 would then ask for another one. LPN-A reviewed the electronic medical record (EMR) and stated the order instructed to only give one drop into each eye adding, "I messed up."

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F 755	Continued From page 61 R26's Physician Order dated 2/21/18, identified a diagnosis of conjunctivitis (pink eye) and listed an order for, "Prednisone 1% ophthalmic gtts [drops] [four times a day for two weeks]." The order lacked any dosing for the drops (i.e. one drop, two drops). R26's medical record was reviewed and lacked any evidence the order had been clarified to ensure the intended dosing was being met and administered correctly, and consistently. When interviewed on 2/28/18, at 8:34 a.m. LPN-A stated the order was unclear and should have been clarified when it was obtained several days prior. During interview on 3/1/18, at 2:50 p.m. the director of nursing (DON) stated the nurses were supposed to be double checking the orders to ensure they were "correctly inputted." The DON stated the process needed to be reviewed and something else needed to be put into place if errors were being found. The DON further stated resident orders should be correctly transcribed and clarified to ensure the right person, right drug, right route and "all of those good things."	F 755		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were administered in accordance with accepted	F 759	Preparation and/or execution of this report of correction does not constitute admission or agreement by the provider of	4/2/18

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F 759	Continued From page 62 standards of practice for 2 of 3 residents (R52, R55) observed to receive medications through a feeding tube. This resulted in a medication administration error rate of 17.8% (percent). Findings include: R52's signed Order Summary Report, printed 2/28/18, identified R52 received an enteral (feeding tube) feeding every 24 hours, water flush of 100 milliliters (ml) via feeding tube every 4 hours and as needed, and a regular mechanical soft diet was added on 2/27/18. The order summary further included: -Cholecalciferol (Vitamin D3) 1000 units via gastrostomy (G-) tube one time a day for supplement, -Gabapentin (used to treat seizures or pain) capsule 300 milligrams (mg), give 600 mg via G-tube three times a day for convulsions, -Keppra solution (used to treat seizures) 100 mg/ml, give 7.5 ml via G-tube two times a day for convulsions, -Vimpat solution (used to treat partial-onset seizures) 10 mg/ml, give 10 ml via G-tube two times a day for convulsions. -Metoprolol Tartrate solution (treat high blood pressure) 10 mg/ml, give 5 ml via G-tube two times a day related to high blood pressure. A physician's telephone order, dated 2/27/18, included Oxycodone (used to treat pain) 5 mg one tab via G-tube every 4 hours as needed for pain. During an observation on 2/28/18, at 7:42 a.m. licensed practical nurse (LPN)-F prepared medications for R52 at a medication cart outside	F 759	the truth of the facts set forth in the statement of deficiencies required by the provisions of the federal and state law. It is the policy of Talahi Nursing and Rehab to be free of Medication Errors. The Policy titled: Medication Incident/Error Policy and Procedure has been review and has been modified to ensure proper education/protocol has been provided/followed for all licensed or unlicensed staff according to state guidelines. The Policy titled: Tube Feeding has been reviewed and removed. A new policy is in place titled: Tube Feeding-Administering Medications. An order to individually crush medication with specific flushes between medications when administering via G-tube has been obtained for R52. An order was obtained for R55 t to individually crush medication with specific flushes between medications. No adverse effects noted for R52 and R55. Orders for residents currently receiving tube feedings have been received to indicate drug compatibility, and to individually crush medication with specific flushes between medications. A task was initiated in the MAR to ensure that all new medications are administered individually with specific flushes in between depending on residents fluid restrictions. A medication order/error audit tool has	

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F 759	Continued From page 63 of her room. LPN-F placed a tablet of Vitamin D3 and a tablet of Oxycodone into one plastic medication cup, two capsules of Gabapentin in a second cup, measured 7.5 ml of Keppra solution into a third medication cup, measured 10 ml of Vimpat solution into a fourth cup, and measured 5 ml of metoprolol tartrate liquid into a fifth cup. LPN-F removed the Vitamin D3 and Oxycodone from the clear medication cup, crushed them together, and poured the two crushed medications back into the medication cup. LPN-F then opened each of the two Gabapentin capsules and dumped the powdered contents into the cup containing the crushed Vitamin D3 and Oxycodone, and added approximately 30 ml of water to the cup LPN-F stated there was an order to "cocktail" the medications, and attempted to show the surveyor the order in the electronic medication administration record (EMAR), but stated, "I don't see one for her," and added, "Maybe it's in her paper chart." Although LPN-F didn't identify an order to mix and administer the medications together, she proceeded to R52's room with the four medication cups and 95 cc of water. Upon entering R52's room with LPN-F, R52 was lying in her bed with her head elevated. LPN-F attached a 60 cc (cubic centimeters) syringe to the end of the feeding tube, checked for residual, flushed 30 cc of water into the tube, and then poured the combined crushed medications mixed with water into the syringe, followed with a water flush. LPN-F then poured each of the liquid medications, separately into the syringe and followed each with a water flush. LPN-F removed the syringe and secured the plug on the feeding tube. LPN-F repositioned R52 per her request, and left the room. When interviewed on 2/28/18, at 7:56 a.m. LPN-F	F 759	been developed and initiated for all three RN Case Managers or three residents three times a week for a minimum of six weeks, to ensure proper administration of medications. Audits will be on going to ensure proper compliance. All Nursing staff have been re-educated on the policies: Medication Incident/Error and Tube Feeding-Administering Medications. IDT/QAPI to meet monthly to evaluate the outcome of these audits and determine appropriate action to follow or make recommendations. DON/RN Case Managers/Designee is Responsible.	

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again searched for an order in the EMAR, and stated there was no order to cocktail R52's medications, but it was possible that the order was in her paper chart. LPN-F stated this was the practice in the facility for residents receiving medications through a feeding tube. LPN-F stated she didn't know if the three medications that she crushed and administered together, were compatible. LPN-F stated, "A lot of times, I like to do the powders together if they are on limited water. It depends on how well they can tolerate it."

Review of R52's medical record lacked orders to combine medications when administering via G-tube and lacked evidence of a fluid restriction.

R55's signed Order Summary Report printed 3/1/18, identified R55 received a tube feeding and was NPO (nothing by mouth). The listing provided several physician orders including:

- Cholecalciferol (Vitamin D3; a vitamin which helps the body absorb calcium and phosphorus) 5000 units via PEG tube one time a day for anemia (low red blood cells) and;
- Multivitamin Liquid 15 milliliters (ml) via PEG tube one time a day for a gastrointestinal tract tumor.

Further, these orders listed a directive by the physician which read, "May cocktail [combine]

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compatible meds to give via g-tube [gastrointestinal tube]." The orders lacked any direction or dictation as to which medications were considered compatible or not compatible to mix and administer together.

During observation on 2/27/18, at 11:41 a.m. licensed practical nurse (LPN)-C prepared medications for R55 at a mobile cart in the hallway outside her room. LPN-C removed five tablets of Vitamin D3 (total dose of 5000 units) from its packaging and crushed them, placing the crushed powder into a white Styrofoam cup. LPN-C then measured 15 ml of liquid Multivitamin using a clear medication cup and mixed it together with the crushed tablets. R55 was laying in bed with her head elevated when LPN-C and the surveyor entered the room. LPN-C stopped the running tube feeding and attached a 60cc (cubic centimeters) syringe to the end. The combined medications were then poured into R55's PEG tube, and followed with a water flush. LPN-C removed the syringe and then reattached the tube feeding; resuming it immediately following.

When interviewed on 2/27/18, at 11:54 a.m. LPN-C stated all the residents in the facility with a tube feeding had orders to "cocktail" their medications. LPN-C reviewed R55's electronic medication administration record (EMAR) and read aloud an order that indicated "may cocktail compatible meds to give via g-tube." LPN-C stated she was unaware which of R55's medications would be considered compatible to give together adding, "I wouldn't know that." LPN-C indicated the pharmacy or medication label would have to identify that information so the nurses would be aware.

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During interview on 2/28/18, at 2:18 p.m. the consulting pharmacist (CP) stated she had no concerns with medications being combined and adminsitered together in a feeding tube "as long as they have an order to do that." Several reasons were presented related to whether to combine or not combine medications for administration through a tube, including fluid restrictions or ease of administration, however, CP reiterated having a physician order would "over ride" these things, regardless of standard of practice(s).

When interviewed on 3/1/18, at 2:50 p.m. the director of nursing (DON) stated medications administered through a feeding tube should be "slurried" and administered seperately with water in-between each medication adding that was "supposed to be what's happening." DON reviewed R55's physician orders and verified it lacked direction or indications on which medications could be combined for administration. R55 did not have any formal orders in place for fluid restriction and the DON added she "would prefer" to see staff administer the medications "one at a time with a flush in between," so the medications are "more effective and will absorb better." Further, DON clarified not following policies and procedures could result in a medication error.

A facility Medication Administration Through Tube Feeding policy dated 11/2017, identified a procedure which included to administer medications using syringe. Further, additional directions identified, "If more than one medication is to be administered, give each one seperately and rinse tube with 5 cc [ml] of warm water in

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F 759	Continued From page 67 between medications."	F 759		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure transdermal narcotic pain patches were applied correctly for 1 of 1 residents (R64) reviewed who had a patch incorrectly applied. This resulted in a significant medication error for R64 who had increased pain as a result. Findings include: R64's quarterly Minimum Data Set (MDS) dated 1/31/18, indicated R64 had moderate cognitive impairment and was independent with transfers and ambulation. R64 had medical diagnoses including mastitis (inflammation of the breast), peripheral neuropathy, osteoarthritis and other chronic pain. Further, the MDS identified R64 was on a scheduled pain medication regimen, had received as-needed (PRN) pain medication during the assessment period and rated her pain level as a four of 10 (10 being the highest). R64's medical record was reviewed. A Physician Communication Form dated 2/23/18, identified R64's Fentanyl patch (narcotic transdermal patch) "was not applied appropriately on 2/20," as staff had only removed 1/2 of the plastic backing before pressing it to R64's skin. The form indicated R64's physician and the director of nursing (DON) were updated when the error was	F 760	Preparation and/or execution of this report of correction does not constitute admission or agreement by the provider of the truth of the facts set forth in the statement of deficiencies required by the provisions of the federal and state law. It is the policy of Talahi Nursing and Rehab to be free from significant Medication Errors. The Policy titled: Medication Incident/Error Policy and Procedure has been review and has been modified to ensure proper education has been provided to the licensed or unlicensed staff according to state guidelines. The current Medication error form has been reviewed and modified to include a check mark system to ensure that proper education/prevention of future errors is provided for all licensed and unlicensed staff, proper physician notification as well as all signatures with review dates to ensure systemic concerns have been identified. R64's patch was immediately reapplied correctly staff were immediately educated	4/2/18

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F 760	Continued From page 68 found. Additional dictation was written which identified, "[R64] has been having [increased] pain. Increased Fentynal [sic] patch 2/21/18." The form was signed completed on 2/22/18. During interview on 2/27/18, at 8:16 a.m. licensed practical nurse (LPN)-B stated she was the nurse currently caring for R64. LPN-B stated she had not received any education or re-training on application of transdermal patches since 2/22/18. When interviewed on 2/27/18, at 8:33 a.m. LPN-C stated she worked with R64 at least weekly and had not receive any education since 2/22/18, on the application of transdermal patches. LPN-C stated it was important to ensure they were applied correctly to make sure the patient is getting the "full amount" of medication. During interview on 2/27/18, at 10:15 a.m. registered nurse (RN)-A stated she heard about the medication error regarding R64's Fentanyl patches, but had "not been privy to" any new education or direction on ensuring the transdermal patches were applied correctly. On 2/27/18, at 3:13 p.m. the DON was interviewed regarding R64's medication error. The DON stated the nurse who committed the error stated she "couldn't see" the plastic backing on the patch so it had not been fully removed before being applied to the resident. DON stated, "We did immediately educate her," adding she could provide documentation to support this. DON explained they had not educated any of the other staff on transdermal patch application because it had happened the week prior and then the health survey started, so it was "on our list to do." The DON further explained a significant	F 760	for proper application/administration. All other residents receiving transdermal patches have been assessed to ensure proper application/administration. R64 was assessed for signs and symptoms of increased pain. A medication order/error audit tool has been developed and initiated for all three RN Case Managers or three residents three times a week for a minimum of six weeks, to ensure proper administration of medications in an effort to reduce medication errors. Audits will be on going to ensure proper compliance and education has been provided. All Nursing staff have been re-educated on the policies: Medication Incident/Error, Tube Feeding-Administering Medications and transdermal patch application/administration. IDT/QAPI to meet monthly to evaluate the outcome of these audits and determine appropriate action to follow or make recommendations. DON/RN Case Managers/Designee is Responsible.	

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F 760	Continued From page 69	F 760		

medication error could result from an incorrect dose, wrong person or if "any of the five rights" were missed.

The DON provided R64's Medication Error Report dated 2/23/18, which identified a date of error as 2/20/18, found during a bath on 2/21/18. The medication ordered was, "Fentanly [sic] Patch 50 mcg [micrograms]," with handwritten "applied only 1/2 the patch," listed below. A question of, "What effect did the error have on the resident[?]," was listed and answered by staff as, "resident had increased pain." An additional question was listed asking what precautions could be taken to prevent a similar error with, "more education," being written along with a, "Corrective Action" which included, "educate staff on importance of proper medication administration."

The form had three spaces for signatures including the person finding the error, the person making the error and the supervisor. The space provided for the person finding the error was left blank and unsigned. The space provided for the person making the error was unsigned, "Refused to sign" was written in the space provided. The supervisor signed the form and dated it 2/23/18. Further, on the back of the form was handwritten scribing which read, "Educated staff to disgard [sic] old patch with another nurse. When you apply the next patch[,] put in another location. Take all plastic pieces [sic] off patch. Make sure patch is firmly placed on resident." This handwritten scribing lacked evidence staff members had received the education to prevent potential future errors. Further, the form lacked a signature from DON to demonstrate it had been reviewed to determine if systemic concern(s) had been identified.

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F 760	Continued From page 70 A facility Medication Incident/Error Policy and Procedure dated 11/2017, identified an objective to "use medication errors as an opportunity to correct the root causes of the error and improve the safety of the medication program." A procedure was listed which directed staff to complete a Medication Incident/Error Report and determine if the error was significant or not. The policy had dictation to refer to F333 (old regulation[s] for significant medication errors) and listed a significant error as one which "...causes the resident discomfort or jeopardizes the resident's health of safety." Further, the policy directed the DON and nurse to discuss the error to evaluate the problem and decide what needs to be done to prevent the error from happening again.	F 760		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents,	F 880		4/2/18

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F 880	Continued From page 71 staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880		

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F 880	Continued From page 72 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure proper hand washing and glove usage was implemented for 1 of 1 Residents R (21) observed with contact precautions. Findings include: R21's diagnosis report printed 3/1/18, identified a primary admitting diagnosis of: carrier or suspected carrier of methicillin susceptible staphylococcus aureus (MRSA). R21's comprehensive assessment (CAA) dated 10/18/17 identified cognitive loss. R21, care plan last review 1/25/18, indicated he was on contact isolation for MRSA- colonization to wounds in hands and legs. Care planned interventions included: educate resident/family/caregivers on the importance of hand washing. Use antibacterial soap and disposable towels. Wash hands immediately after ADLS,([activities of daily living) care tasks and activities , wear disposable gloves and gown when in residents room and wash hands before entering and after leaving. During an observation from the hallway, on	F 880	Preparation and/or execution of this report of correction does not constitute admission or agreement by the provider of the truth of the facts set forth in the statement of deficiencies required by the provisions of the federal and state law. It is the Policy of Talahi Nursing and Rehab to provide and established Infection prevention and control program. The policy titled: Isolation Precautions has been reviewed and is accurate. The policy titled: Hand Hygiene has been reviewed and is accurate. LPN-E and NA were re-educated on proper isolation technique. All staff have been re-educated on the policies titled: Isolation Precautions and Hand Hygiene. Daily audits to be conducted for a minimum of two weeks will be conducted to ensure proper isolation technique. Followed by three audits weekly for three weeks then weekly audits for three weeks.	

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F 880	Continued From page 73 2/28/18, at 9:17 a.m., licensed practical nurse (LPN)- E stood outside R21's and donned a yellow gown and gloves, then entered the room. Isolations items were observed in a three drawer plastic cart at the entrance to R21's room. On top of cart was a sign indicating, "check with nurse before entering." LPN-E lifted R21's shirt and gave an injection. Wearing gown and gloves LPN-E then walked out of the room and walked to the medication cart across the hall. LPN-E removed her gloves but did not use hand sanitizer or wash her hands. LPN-E opened the medication cart drawer and removed a plastic cup with bare hands. LPN-E donned gloves, picked up the plastic medication cup and container of pudding and re-entered R21's room. After administering the medication, LPN-E was observed to remove the gown and one glove, then walked out of R21 room over to the medication cart carrying a portable phone in her right hand. LPN-E then opened the lower drawer, and pulled out a container of sanitizing wipes. LPN-E used a sanitizing wipe to wipe off the phone then wrapped the phone in the cloth and used hand sanitizer on both hands. During an interview on 2/28/18, at 9:24 a.m. with LPN-E stated had not washed her hands after providing cares to R21. LPN-E further stated should have washed her hands each time she left R21 room. LPN-E stated she knew R21 was on contact precautions but was not sure for what reason. During an interview on 2/28/18, at 2:57 p.m. the director of nursing (DON) stated she expected staff to wash their hands before entering a residents room and after changing gloves. DON further stated the expectation was for staff to	F 880	IDT/QAPI to meet monthly to evaluate outcome of these audits and determine appropriate action to follow or make recommendations. DON/Designee is Responsible	

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F 880	Continued From page 74	F 880		

wash hands as often as the cares they are providing indicated to ensure proper handwashing and glove usage.

During an observation from the hallway, on 3/1/18, at 10:33 a.m. nursing assistant (NA)-D assisted R21 to put his coat on. NA-D was observed picking up several items in R21's room. NA-D did not wash hands or use hand sanitizer as she left the room. NA-D then walked down the hallway, opened a staff office door and came out with her coat and purse.

During an interview on 3/1/18, at 10:35 a.m. NA-D stated, she had not washed her hands or donned gloves while in R21's room. NA-D further stated she should have donned gloves and washed hands when leaving the room.

During an interview on 3/1/18, at 11:00 a.m. registered nurse(RN)-D stated R21 was on contact precautions for MRSA in hand and leg wounds. RN-D stated she would expect staff to gown and glove when providing cares. RN- D further stated she expected staff to take off gloves and immediately wash hands before leaving R21's room. RN-D stated R21's isolation precaution is communicated to staff on the care plan and kardex.

Facility policy, Hand Hygiene, dated 11/2017, indicated "staff will perform hand hygiene by washing hands for at least fifteen seconds with antimicrobial's or non- microbial soap and water. Hand hygiene should be performed before entering or leaving an isolation room, and after providing direct resident care. "

Facilty policy titled, Isolation Precautions, dated,

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F 880	Continued From page 75 1/2017, indicated contact precautions should be implemented for residnets suspected or confirmed to be infected with a communicable disease/infection that can be transmitted by direct contact with the residnets or indirect contact with Environemental services/equipment in the residnets environment. The policy directed staff to perform hand hygiene and to apply gloves and gown prior to entering the room, and remove gloves and perform hand washing before leaving the room.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza	F 883		4/2/18

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F 883	Continued From page 76 immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the appropriate pneumonia vaccine (Pneumococcal 13-valent Conjugate Vaccine-PCV13) was offered and provided for 1 of 5 residents (R51) reviewed for immunizations. Findings include:	F 883	Preparation and/or execution of this report of correction does not constitute admission or agreement by the provider of the truth of the facts set forth in the statement of deficiencies required by the provisions of the federal and state law. It is the Policy of Talahi Nursing and Rehab to provide and established	

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F 883	Continued From page 77 R51's Admission Record, undated, indicated R51 was admitted on 7/13/14, was currently 68 years of age, and had diagnoses that included chronic obstructive pulmonary disease and nicotine dependence. The Center for Disease Control and Prevention (CDC) identified, "Adult 65 years of age or older who have not previously received PCV13 and who have previously received one or more doses of PPSV23 (pneumococcal polysaccharide vaccine 23) should receive a dose of pneumococcal 13-valent Conjugate Vaccine (PCV13). The dose of PCV13 should be administered at least one year after the most recent PPSV23 dose." R51's Minnesota Immunization Information Connection (MIIC) report, printed 3/1/18, indicated R51 had received a Pneumo-PPSV23 (a vaccine for specific strains of pneumonia) on 3/29/01 and 9/1/09, prior to the age of 65. R51's immunization record lacked evidence of a PCV13 vaccine as recommended by the CDC. During an interview on 3/1/18, at 3:46 p.m. assistant director of nursing (ADON) stated residents' immunizations were checked on admission to ensure they were up-to-date, by checking the MIIC website for the current immunization records, and if they were not current, the facility educated, encouraged, and offered the immunizations. ADON stated she had reviewed immunization records for residents that had been in the facility previously and verified R51 had not received the appropriate pneumonia vaccination. ADON stated R51 had a representative and, although ADON stated he had been sent two letters informing of R51's need	F 883	Infection prevention and control program. The Policy titled: Pneumococcal Vaccination has been reviewed and modified to utilize Point Click Care (PCC) Immunization tab for all residents and to scan consent forms into the system. The DON was informed of the lack of documentation regarding the PCV13 vaccination on R51. The ADON did immediately obtained a signature from R51 stating that R51 did not want the PCV13 vaccination and did not want to be asked again. All residents were reviewed to ensure proper notification and documentation is in place. An immunization tracking system is available on Point Click Care (PCC). The immunization tab for all residents including R51 have been updated with consents scanned into PCC. All Nursing staff have been re-educated on the Policy titled: Pneumococcal Vaccination and new procedure for use of PCC for accuracy and compliance. With new process added for all new admissions. An Audit for all new admissions for a minimum of six weeks to ensure compliance. IDT/QAPI will meet monthly to evaluate outcome of these audits and determine appropriate action to follow or make recommendations.	

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F 883	Continued From page 78 for the PCV13 vaccine, there was no documentation, and no process in place to ensure follow up if no response was received. Review of the facility's policy and procedure, Pneumococcal Vaccination, revised 9/9/17, included, "All residents will be assessed for appropriateness of receiving the pneumococcal vaccine. Residents who have been deemed as appropriate for receiving the pneumococcal vaccine and who consent to receiving the vaccine will be given the vaccine following the CDC guidelines for the administration of the PPSV23 and PCV13 as per the recommendations on the CDC website."	F 883	DON/Designee is Responsible.	
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure vertical blinds were kept in a state of good repair to provide visual privacy in 1 of 1 resident rooms (Rm. 109) observed to have blinds in disrepair. In addition, the facility failed to ensure bathroom door(s) were kept in good repair to prevent scratches and splinters in 1 of 5 resident rooms (Rm. 171) toured during survey. These concerns had potential to affect 3 of 3 residents identified to use the rooms. Findings include:	F 921	Preparation and/or execution of this report of correction does not constitute admission or agreement by the provider of the truth of the facts set forth in the statement of deficiencies required by the provisions of the federal and state law. It is the policy of Talahi Nursing and Rehab to ensure that all residents are provided with a safe, functional, sanitary and comfortable environment. The policy titled: How to request Maintenance repairs has been reviewed	4/2/18

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F 921	Continued From page 79 VERTICAL BLINDS: On 2/26/18, at 3:49 p.m. Rm. 109 (a single room with one resident residing inside) was observed on the "Rosewood" unit. The room had a large window along the far wall which had white colored, plastic vertical blinds which were pulled closed. There were several sections and pieces of the vertical blinds missing which allowed the outside street and sidewalk to be visible while inside the room, despite the blinds being closed. Further, there were two pieces of the vertical blinds laying on the window sill. During subsequent observation on 3/1/18, at 9:23 a.m. Rm. 109 continued to have missing pieces of the vertical blinds with a single piece now sitting on the window sill. The outside street was visible, despite the blinds being pulled closed, and people were walking on the sidewalk. On 3/1/18, at 9:47 a.m. nursing assistant (NA)-E observed Rm. 109's blind(s) with the surveyor and stated they should be repaired. NA-E "didn't realize how open" the blinds caused the outside street and sidewalk to be despite being closed adding "it needs to be fixed," as it was "a privacy issue." On 3/1/18, at 1:04 p.m. an environmental tour was completed with the director of maintenance (DM). DM explained each resident room was checked on a monthly basis for repairs, however, many times when they walk by the room doors were closed. DM observed the vertical blinds in Rm. 109 and stated "they needed to be serviced," adding it, "doesn't take much to break them." DM stated the floor staff should have notified him the blinds were in disrepair so they could be	F 921	and is accurate. The vertical blinds in room 109 were immediately repaired, by the Director of Maintenance. The scuff mark in the bathroom door in 171 was repaired by maintenance. Maintenance performs a daily walk through the facility to inspect and repair items as identified. Resident Room audit implemented for three residents three times a week for a minimum of six weeks to ensure all residents have a safe, functional, sanity and comfortable environment at all times. All staff have been re-educated on the Policy titled: How to Request Maintenance Repairs. IDT/QAPI to meet Monthly to evaluate outcome of these audits and determine appropriate action to follow or make recommendations. Director Maintenance/Administrator/ Designee is Responsible	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 921	Continued From page 80	F 921		

addressed as there was a "busy street" outside the window and resident privacy should be maintained.

A facility policy and/or procedure on vertical blind tracking and maintenance was requested, however, none was provided.

DOOR IN DISREPAIR:

On 2/26/18, at 1:26 p.m. Rm. 171 (a shared room with two residents residing inside) was observed. The room had a shared, single bathroom with a wooden door. The door had a visible hole with rough, jagged edges on the outside which appeared to be several inches in length. Further, visible wood shards extending around the perimeter of the hole were rough to touch.

On 3/1/18, at 1:04 p.m. an environmental tour was completed with the director of maintenance (DM). DM explained each resident room was checked on a monthly basis for repairs, however, many times when they walk by the room doors were closed. DM observed Rm. 171's bathroom door and stated it "needs attention," and should be serviced or replaced. DM measured the hole and stated it was approximately 3 inches in length and staff should be letting him know when things need repair(s) adding "if you see it, take care of it."

A policy and/or procedure was requested on room maintenance, however, none was provided.

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on February 28, 2018. At the time of this survey, Talahi Care Center was found in not compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/26/2018

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

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K 000	Continued From page 1	K 000		

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 and
Angela.Kappenman@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

Talahi Center is a 1-story building, plus a partial basement, facility was originally constructed in 1967 with additions in 1969, 1984, 1998 and 2005. The 2005 addition had its plan review completed in 2002. The facility was determined to be Type II(000) construction. 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

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K 000	Continued From page 2 77 beds and had a census of 73 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide unobstructed access to the corridor from resident exam room and other areas with a required exit as required by the Life Safety Code (NFPA 101) 2012 edition section 19.2.2 & 7.1.10.1. This deficient practice could affect the exiting ability of an undetermined amount of residents, staff and visitors. Findings include: On the facility tour between 8:30 am to 1:30 pm on 02/28/2018 observations and staff interview revealed combustible storage and other materials reducing the passageway of Fernwood Lane and in the Therapy Area. This deficient condition was confirmed by the Director of Maintenance.	K 211	obstructed corridors were immediately cleared. All areas to remain free of clutter. Maintenance to ensure clearance of all corridors with daily rounds. A tracking system has been put in place to ensure compliance Administrator/Maintenance Director/Designee is Responsible	4/10/18

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K 300 SS=E	Protection - Other CFR(s): NFPA 101 Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to provide the proper protection of floor penetrations as required by NFPA 101 (12). The Life Safety Code section 8.3.1 and 8.3.3. This deficient practice could allow for the spread of fire and smoke to enter other smoke compartments. This could affect an 20 of 77 residents and a undetermined amount of staff and visitors. Findings include: During the facility tour from 08:30 am to 1:30 PM on 2/28/2018 observations and staff interview revealed the fire door adjacent to the boiler room in Rosewood Lane did not close tight. This deficient condition was confirmed by the Director of Maintenance.	K 300	The fire doors on our Rosewood Unit adjacent to the boiler room have been ordered and will be replaced immediately upon delivery to the facility. Administrator/Maintenance Director/Designee is Responsible.	4/10/18
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier	K 321		4/10/18

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K 321	Continued From page 4 having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility to maintain a hazardous storage room in accordance with the 2012 Life Safety Code (NFPA 101) section 19.3.2.1.3. This deficient condition could allow smoke or fire to enter the corridor making it untenable and affect the quick and efficient exiting for 21 of the 77 residents and an undetermined amount of staff and visitors. Findings include:	K 321	Spring hinges to the storage room have been installed. Administrator/Maintenance Director/Designee is Responsible	

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K 321	Continued From page 5 On the facility tour between 8:30 am to 1:30 pm on 02/28/2018 observations and staff interview revealed the activities room has been changed into a storage from from a sensory room and does not have a self closer. This deficient condition was confirmed by the Director of Maintenance.	K 321		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on documentation review and interview, the Facility failed to test and maintain the Fire Alarm System in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25. The deficient practice could affect all 77 patients and an undetermined amount of visitors and staff.	K 345	The DACT system has been tested and is in compliance. A tracking form was reinitiated to ensure monthly testing. Administrator/Maintenance Director/Designee is Responsible	4/10/18

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K 345	Continued From page 6 Findings include: On 02/28/2018 at 9 AM, documentation reviewed revealed that the DACT System was not tested monthly during the following times: 1) 1st quarter 3rd shift of 2017 2) 2nd quarter 1st through and 3rd shift of 2017 3) 3rd quarter 1st and 2nd shift of 2017 4) 4th quarter 3rd shift of 2017 This deficient condition was confirmed by the Director of Maintenance.	K 345		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the Facility	K 353	The Sprinkler system annual inspection	4/10/18

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K 353	Continued From page 7 failed to maintain the ceiling in the Main Street Corridor in accordance with 9.7.5, 9.7.7, 9.7.8, and NFPA 25. This deficient practice could affect 29 out of 77 residents. Findings include: On the facility tour between 8:30 am to 1:30 pm on 02/28/2018 observations and staff interview revealed that numerous drop in ceiling tiles were missing thoughout the facility. In a housekeeping closet by Rosewood Lane, an HR Storeroom and an IT Closet. These missing ceiling tiles will adversely effect the operation of nearby fire sprinkler heads and smoke detectors by allowing the passage of heat and smoke through the ceiling. This deficient condition was confirmed by the Director of Maintenance.	K 353	was completed by Brothers Fire on /8/18. Our water supply is through the city of St. Cloud. The ceiling tiles have been replaced and will be monitor by all staff to ensure compliance. Administrator/Maintenance Director/Designee is Responsible.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and 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. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the	K 712	A fire drill was completed on 3/22/18. Fire	4/10/18

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K 712	Continued From page 8 facility failed to provide documentation of fire drills at least quarterly on each shift as required by the Life Safety Code (NFPA 101) 2012 edition, section 19.7.1.4 to 19.7.1.7. This deficient practice could reduce the ability of staff to conduct a safe and timely response to a fire emergency, which would affect all 77 residents and an undetermined amount of staff and visitors. Findings include: On facility tour between 8:30 AM and 1:30 PM on 02/28/2018, documentation reviewed revealed that Fire drills were not performed during these times: 1) 1st quarter 3rd shift of 2017 2) 2nd quarter 1st through and 3rd shift of 2017 3) 3rd quarter 1st and 2nd shift of 2017 4) 4th quarter 3rd shift of 2017 This deficient condition was confirmed by the Director of Maintenance.	K 712	drills will be conducted monthly. Maintenance to ensure every shift quarterly. Tracking sheet reinitiated. Administrator/Maintenance Director/Designee is Responsible.	
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced	K 901		4/10/18

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K 901	Continued From page 9 by: Based on documentation review and staff interview, the facility failed to inspect the building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. The deficient practice could affect all 77 residents. Findings include: During documentation review between 8:30 AM and 1:30 PM on 02/28/2018, documentation review and staff interview revealed the required risk assessment NFPA 99 had not been started at the time of the survey. This deficient condition was confirmed by the Director of Maintenance.	K 901	NFPA 99 risk assessment has been completed. Administrator/Maintenance Director/Designee is Responsisble	
K 912 SS=F	Electrical Systems - Receptacles CFR(s): NFPA 101 Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Electrical Systems - Receptacles Power receptacles have at least one, separate,	K 912	The generator has been inspected. A tracking form has been developed to	4/10/18

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K 912	Continued From page 10 highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.4.2 (NFPA 99) This deficient practice could affect 77 of 77 residents. Findings include: During documentation review on 02/28/2018, documentation could not be located to show that an electrical outlet inspection had occurred throughout the facility. This deficient condition was confirmed by the Director of Maintenance.	K 912	ensure weekly and annual inspections in accordance with NFPA 110 A GFI tester has been purchased and all GFI'S have been tested and will be tested monthly. Administrator/Maintenance Director/Designee is Reponsible	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test	K 918		4/10/18

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	245438	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/28/2018**

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

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K 918	Continued From page 11 under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide test documentation in accordance with the 2012 edition of the Life Safety Code (NFPA 101) section 9.1.3.1 and the 2010 edition of NFPA 110 the Standard for Emergency and Standby Power Systems. This deficient practice could affect the safety of all of the 77 residents if the generator failed to operate during a power outage. Findings include: On the facility tour between 8:30 am to 1:30 pm on 02/28/2018 record review and staff interview revealed: 1) no record of 6 of the 12 monthly generator tests. March - August 2017 2) weekly generator testing documentation	K 918	The generator has been inspected. A tracking form has been developed to ensure weekly and annual inspections in accordance with NFPA 110 Administrator/Maintenance Director/Designee is Reponsible	

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K 918	Continued From page 12 missing from March - July 2017 3) Last load bank performed October 30th, 2015 This deficient condition was confirmed by the Director of Maintenance.	K 918		
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure a multiple outlet connection was in accordance with the 2012	K 920	Multiple outlet connection cord was removed. All staff education provided on use of electrical cords or equipment in	4/10/18

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K 920	Continued From page 13 edition of NFPA 99 section 10.2.3.6 item 2 for total ampacity. This deficient practice could cause an overload of a circuit which could cause a power outage to necessary equipment or cause a fire. This could affect all 77 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:30 am and 1:30 pm on 02/28/2018, observations and staff interview revealed: 1) In room 165 an extension cord was plugged into the wall. This deficient condition was confirmed by the Facility Maintenance Director.	K 920	residents rooms. Administrator/Maintenance Director/Designee is responsible	
K 923 SS=E	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating.	K 923		4/10/18

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K 923	Continued From page 14 Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to store oxygen tanks in accordance with NFPA 99 (Health Care Facilities Code) 2012 edition section 11.6.2.3 item 11. This deficient practice could create an oxygen filled atmosphere and accelerate the spread of fire. This condition could affect all of the 77 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:30am to 1:30 pm on 02/28/2018, observations and staff interview revealed full and empty oxygen tanks combined in the same area in both O2 rooms.	K 923	Oxygen tanks were immediately separated to ensure staff and resident safety. A tracking form developed to ensure daily inspection for compliance. Administrator/Maintenance Director/Designee is responsible.	

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K 923	Continued From page 15 This deficient condition was confirmed by the Facility Maintenance Director.	K 923		
K 926 SS=F	Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This could affect all 77 residents and an undetermined amount of staff and visitors. FINDINGS INCLUDE: During documentation review on 02/28/2018, documentation could not be located to show that staff that handle medical gas have been properly trained per NFPA 99. This deficient practice was verified by the Facility	K 926	All staff have been properly trained on the handling of medical gas. Training initiated upon hire and annually thereafter. Administrator/Maintenance Director/Designee is responsible	4/10/18

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K 926	Continued From page 16 Maintenance Director.	K 926		