

#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

March 6, 2017

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

Subject: Talahi Nursing And Rehab Center - IDR

Provider # 245438 Project # S5438028

Dear Ms. Smith:

This is in response to your letter of January 6, 2017, in regard to your request of an informal dispute resolution (IDR) for the federal deficiencies at tag F244, F364, and F425 issued pursuant to the survey event J6VE11, completed on December 8, 2016.

The information presented with your letter, the CMS 2567 dated December 8, 2016 and corresponding Plan of Correction, as well as survey documents and discussion with representatives of L&C staff have been carefully considered and the following determination has been made:

F244 S/S - (E) §483.15(c) Participation in Resident and Family Groups (f)(5) The resident has a right to organize and participate in resident groups in the facility.

#### Summary of the facility's reason for IDR of this tag:

The facility asserts the resident council is only one venue for residents to voice concerns. The administrator and director of nursing maintain they make themselves available for residents during routine facility rounds. In addition, the administrator and director of nursing assert they had not been made aware that residents wanted them to attend the resident council meetings, and that they would make efforts to attend now that this has been brought to their attention. They also reiterated that a staff member does regularly attend the resident council meetings to take minutes, and to bring any concerns forward. They confirmed no concerns had been brought forward for follow up.

<u>Summary of the facts:</u> F244 is a regulation to ensure residents have the right to meet as a group. The facility is responsible to consider the views of the resident group and act promptly upon the grievances and recommendations concerning issues of resident care and life in the facility. In addition, the facility must be able to demonstrate their response and rationale for such response. However, the regulation is not to be construed to mean that the facility must implement as recommended every request of the resident group. The facility had assisted residents to meet as a group. There was no specific grievance identified that the facility had failed to address.

Talahi Nursing And Rehab Center March 6, 2017 Page 2

#### **Summary of findings:**

After review of the 2567, information provided by the facility, and discussion with licensing and certification staff, it was determined there was insufficient evidence to support a deficient practice.

F244 as written, does not reflect a valid example of a deficient practice and will be removed from the 2567 Statement of Deficiencies.

F364 S/S - (B) §483.35 (d) Food

Each resident receives and the facility provides (d) (2) Food that is palatable...

#### Summary of the facility's reason for IDR of this tag:

The facility disputed the findings that one resident's complaints about the garlic toast not having enough flavor. They asserted the finding cited was purely subjective, and stated that what was too 'garlicy' to one resident may not seem 'garlicy' enough for another.

#### **Summary of the facts:**

The intent of this regulation is to assure that the nutritive value of food is not compromised and destroyed because of prolonged food storage, light, and air exposure. Food served to residents is supposed to be palatable. Other than one resident stating the garlic bread could have more garlic flavor, there was no concern about food palatability. In addition, there were no other residents who complained about the flavor of the garlic bread.

#### Summary of the findings:

After review of the 2567, information provided by the provider, and discussion with licensing and certification survey staff, it was determined there was inadequate evidence to verify a deficiency existed related to palatability of the garlic toast.

F364 does not reflect a valid example of a deficient practice and will be removed from the 2567 Statement of Deficiencies.

#### F425 S/S – (E) §483.60 Pharmacy Services Summary of the facility's reason for IDR of this tag:

The facility asserts the deficient findings related to expiration dates of Tubersol were also addressed in documentation at F431, therefore they do not think these same findings should be issued at F425.

#### Summary of the facts:

It was verified the findings related to the Tubersol expiration dates had in fact already been cited at F431. However, a deficient practice still exists related to R94's Myrebtiq in extended release form, which was determined to have been administered by crushing and/or opening the capsule to administer via G-tube for

Talahi Nursing And Rehab Center March 6, 2017 Page 3

R94. Directions for use of the medication clearly indicated it should not be crushed, chewed, or broken.

#### Summary of the findings:

After review of the 2567, information submitted by the facility and discussion with licensing and certification staff, it was determined this is a valid deficiency at F425 regarding R94's Myrebtiq medication.

The information related to use of expired Tubersol, already appropriately addressed at F431, will be removed from the 2567 Statement of Deficiencies at F425 reducing the scope and severity of F425 to a D, isolated with potential for more than minimal harm.

The revised Statement of Deficiencies is attached.

This concludes the Minnesota Department of Health informal dispute resolution process.

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

Sincerely,

Gloria Derfus, Unit Supervisor Licensing and Certification Program

Health Regulation Division

Telephone: 651-201-3792 Fax: 651-201-9697

Dela sinell

cc: Office of Ombudsman for Long-Term Care Maria King, Assistant Program Manager

Licensing and Certification File

Brenda Fischer, St. Cloud Team A Unit Supervisor

PRINTED: 03/06/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245438	B. WING			12/08/2016	
	PROVIDER OR SUPPLIER NURSING AND REHA	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 1717 UNIVERSITY DRIVE SOUTHEAS SAINT CLOUD, MN 56304			
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F 000	On 12/5/16 to 12/8 was completed by so Department of Hear Rehab Center was with the regulations B, requirements for Department's acception enrolled in ePOC, you at the bottom of the form. Your electronic be used as verificative receipt of an acception-site revisit of your validate that substate regulations has been your verification.  In addition, an invest H5438047 was comated a deficiency cited a investigation of composite completed, and four 483.10(h)(1)(3)(i); 40 PRIVACY/CONFIDE 483.10(h)(l) Personal privation medical treatment, communications, position of family a meetings of family a substance of the privation of the priv	,	F 0	DEFICIENCY)			1/17/17
	confidential person	nas a right to secure and all and medical records.					
I ARODATODY	/ DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	IATLIDE	TITI F			(X6) DATE

Electronically Signed

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

01/04/2017

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F 164	(i) The resident has of personal and me provided at §483.70(i)(2) or oth laws.  §483.70 (i) Medical records. (2) The facility musinformation contain regardless of the forecords, except wh  (ii) To the individual representative whe (ii) Required by Law (iii) For treatment, poperations, as permote the forecords, except who (iii) For public health neglect, or domestiactivities, judicial at law enforcement pupurposes, research medical examiners a serious threat to by and in compliant This REQUIREMED by:  Based on observar review, the facility for privacy was provided.	t keep confidential all ed in the resident's records, orm or storage method of the en release is- to or their resident re permitted by applicable law; or their downward or the permitted by applicable law; or their downward or the repermitted by applicable law; or their downward or the permitted by applicable law; or their downward or the permitted by applicable law; or their downward or the law; or the law and in compliance	F 16	F000: Preparation and/or execution this report of correction does not constitute admission or agreement provider of the truth of the facts see in the statement of deficiencies recount by the provisions of the federal and law.	by the t forth quired	

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F 164	Continued From pa	age 2	F 164				
	had dementia and individual Residential indicated R94 need dressing, bathing at During observation was lying in bed with R94 was lying on high gown completely obare back and buttout product. R94's dochallway, as staff and Numerous staff we room, but made not cover herself or cloprivacy.  During interview on practical nurse (LF around" and must LPN-A stated (R94 uncovered for other During observation was lying in bed, wopen, exposing he incontinent produce exposed the top of R94's room, and a administering medigust outside of R94 attempts to cover lensure R94's persuring interview 12 director of nursing	in 12/05/16, at 7:09 p.m. R94 ith her sheets pulled down. Her left side, with her hospital pen in the back, exposing her tocks with an incontinent or was completely open to the not visitors walked past. Here observed walking by R94's attempts to assist R94 to ose the door to maintain R94's on 12/05/16, 7:20 p.m. licensed PN)-A stated R94 "fidgets have pulled off her sheets. Here to see.  In 12/06/16, at 7:55 a.m., R94 with the room door completely or back side. R94 wore an att, which had fallen down and ther buttocks. Staff walked by an unidentified nurse was ication from the cart parked the state of the staff made no R94, or close her door to		It is the policy of Talahi Nursing ar Rehab Center provide personal prits residents. The policy has been reviewed, and is accurate.  R94 has been relocated to room which is located in a low traffic are close to the nurse's station.  Staff have been re-educated on the total assure privacy for all residents times. See Exhibit 164A.  Random audits will be completed times per week for three weeks to privacy is protected. IDT/QAPI will evaluate outcome of these audits completion of three weeks and deappropriate action to follow. See Entire the privacy is protected. IDT/QAPI will evaluate outcome of these audits completion of three weeks and deappropriate action to follow. See Entire the privacy is protected. IDT/QAPI will evaluate outcome of these audits completion of three weeks and deappropriate action to follow. See Entire the privacy is protected. IDT/QAPI will evaluate outcome of these audits completion of three weeks and deappropriate action to follow. See Entire the privacy is protected. IDT/QAPI will evaluate outcome of these audits completion of three weeks and deappropriate action to follow. See Entire the privacy is protected. IDT/QAPI will evaluate outcome of these audits completion of three weeks and deappropriate action to follow. See Entire the privacy is protected.	nd rivacy for 171-2 ea but ne policy at all three o assure I at the		

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F 164	working on education	ige 3 I stated the facility will be ng the staff on privacy.  sted for privacy and was not	F 164	1		
F 167 SS=C	483.10(g)(10)(i)(11) RESULTS - READI  (g)(10) The resident  (i) Examine the resof the facility condusurveyors and any respect to the facility (g)(11) The facility (g)(12) The facility (g)(13) The facility (g)(14) The facility (g)(15) The facility shall information about (g)(15) The facility shall information about (g)(15) The facility shall information about (g)(11) The	sults of the most recent survey cted by Federal or State plan of correction in effect with ty; and must eadily accessible to residents, as and legal representatives of the most recent survey of the respect to any surveys, complaint investigations made ity during the 3 preceding of correction in effect with ty, available for any individual usest; and the availability of such reports in that are prominent and	F 16		1/17/17	
	by: Based on observa	tion, interview and document		F167-Servey Results		

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F 167	review, the facility frecent State agency to review. This had residents, visitors at this information.  Findings include:  During the initial tood 11:55 a.m., a blue-of [Minnesota] Dept [Dine Results" was found The survey results 12/16/14 (nearly two additional surveys is review.  When interviewed the health unit coordination in the binder were recompleted survey, toured the building additional survey results 12/16/14 (nearly two additional surveys is review.  When interviewed the building additional survey results was typically kept at a was typically k	ailed to ensure the most y survey results were available a potential to affect all 70 and staff who wished to review are of the facility on 12/5/16, at colored binder labeled, "MN Department] of Health Survey on the West nursing station. Contained inside were dated, to years prior). There was no dentified in the binder to contained in the binder to the most recently HUC-A and the surveyor then and were unable to locate any esults.	F 16	Talahi Nursing and Rehab Center post the results of the most received of the facility in a readily accessified for residents, family members an representatives of residents.  The most current survey is located reception desk in the front lobby, receptionist is responsible to assolocation on a daily basis when should have addressed immediately pointed out by surveyor.  The receptionist maintains a calea audit check off which confirms the book is located on the reception the front lobby. The Administrato confirms accurate placement and maintenance of the calendar cheaccurate placement of the survey QAPI will review these audits at i regularly held meetings and will determine an appropriate schedulongoing audits  A directed in-service was conduct the Administrator by the Regional of Operation on compliance and adherence to ensure the most resurvey results are available at all. The administrator is responsible compliance regularly.	ed on the and the ure its e is here. when endar e survey desk in r d ck for / book.  Its ule for ted by I Director cent times.		

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 225 SS=D	(a) The facility mus (3) Not employ or owho- (i) Have been found exploitation, misapp mistreatment by a continuous exploitation, mistreatment aide registry exploitation, mistreatment by a continuous exploitation of the professional body as a result of exploitation, mistreatment of the professional body as a result of exploitation, mistreatment of the professional body as a result of exploitation, mistreatment of the professional body as a result of exploitation, mistreatment of the professional body as a result of exploitation, mistreatment of the professional body as a result of exploitation, mistreatment of the professional body as a result of exploitation, mistreatment of the professional body as a result of exploitation, mistreatment of the professional body as a result of exploitation, mistreatment of the professional body as a result of exploitation, mistreatment of the professional body as a result of exploitation, mistreatment of the professional body as a result of exploitation, mistreatment of the professional body as a result of exploitation, mistreatment of the professional body as a result of exploitation.	therwise engage individuals  diguilty of abuse, neglect, propriation of property, or court of law;  ing entered into the State concerning abuse, neglect, atment of residents or it their property; or  hary action in effect against his license by a state licensure a finding of abuse, neglect, atment of residents or	F 22	,		1/17/17
	licensing authorities actions by a court of which would indicat nurse aide or other  (c) In response to a exploitation, or miss  (1) Ensure that all a abuse, neglect, exploited injuries of misappropriation of reported immediate after the allegation cause the allegation	ate nurse aide registry or s any knowledge it has of of law against an employee, te unfitness for service as a				

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F 225	the events that cau abuse and do not the administrator officials (including adult protective se for jurisdiction in loaccordance with Sprocedures.  (2) Have evidence thoroughly investig (3) Prevent further exploitation, or mis investigation is in procedures.  (4) Report the resultance administrator or his representative and with State law, included Agency, within 5 wife the alleged violation corrective action of This REQUIREME by:  Based on interview facility failed to ensinguries of unknown reported to the address of unknown reported	use the allegation do not involve result in serious bodily injury, to of the facility and to other to the State Survey Agency and rvices where state law provides ong-term care facilities) in tate law through established.  That all alleged violations are gated.  potential abuse, neglect, streatment while the progress.  Ults of all investigations to the sor her designated in accordance uding to the State Survey torking days of the incident, and the survey forking days of the incident, and the survey forking to the state survey forking days of the incident, and the sure allegations of abuse and in origin were immediately ministrator and/or state agency roughly investigated for 2 of 5 de R33) whose allegations of	F 225	F225- Investigate Allegations  It is the policy of Talahi Nursing and Rehab Center to ensure that all alleviolations involving abuse, neglect, exploitation or mistreatment, includinjuries of unknown source and misappropriation of resident proper reported immediately, but not later hours after the allegation is made, events that cause the allegation invabuse or result in bodily injury, or not that 24 hours if the events that cause allegation do not involve abuse and	eged ing ty, are than 2 if the rolve ot later se the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 225	10:20 a.m. indicate bruise on the top of centimeters (cm) is centimeters (cm) if cm dark, purple are further indicated F and when asked if and nodded. There administrator and notified of the injust thorough investigate the possible cause. During interview of administrator was She thought since smiled after being was probably why The administrator cognitively impaired reported immediate then investigated.  R33's quarterly MI she was severely care plan dated 00 impaired thought processed thought processed impaired thought processed impaired thought processed in the possible cause.  A Incident Report nursing assistant of the possible cause and thought processed in the possible cause.	ent Report, dated 6/9/16 at ed during a bath, R97 had a of her left hand that measured 6 by 4 cm, and was blue, with a 1 rea in the center. The report 197 had no complaints of pain is she bumped it, R97 smiled e was no indication the state agency were immediately by of known origin, nor was a ution completed to determine e of the injury.  In 12/07/16, at 11:00 a.m. the unable to recall the incident. R97 nodded her head and asked if she bumped it, this the incident was not reported. The stated if the resident is ed the report should have been stelly reported to her, SA and DS dated 09/06/16, indicated cognitively impaired. R33's 3/02/15, indicated she had processes and cognitive status, etimer's disease, and had	F2	225	result in serious bodily injury, to the administrator of the facility and to officials (including the state survey and adult protective services where law provides for jurisdiction in long care facilities) in accordance with Slaw through established procedure. The occurrences of R97 and R33 verviewed by the IDT, and complete. The policy and procedure for vulne adult was reviewed and is current.  All suspected vulnerable adult reported to the DON and Administrator per policy guidelines.  DON/Administrator or designee will complete daily audit of progress not and risk management/incident reported ensure update immediately of all incidents and potential VA reports.  An audit tool for vulnerable adult rewas created and is in use to ensure timely notification and completion of investigation. This tool and the find will be reviewed weekly and the mod QA meetings.  Administrator, DON/designee are responsible	other agency e state -term State s. were ed. erable orts are eator	

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F 225	morning cares on 1 and two bruises we on the top of her arcm; and one on the measuring 2 cm by bruises located on measuring 2 cm by underside measure indicated the incide agency on 11/15/16 occurred. There wa administrator and s notified of the incide SA on 11/12/16, but 11/15/16 to report the stated once she wa immediately reported. Review of the facility Abuse Policy and Pindicated all allegat abuse must be reported or witness neglect a report muthe Minnesota Depart also indicated an in	ng R33 by the forearms during 1/12/16. R33 was examined, re found on her left forearm, m measuring two cm by four underside of her arm 2 cm. There were also R33's right forearm, 4.5 cm, and the one on the d 2 cm by 2.5 cm. The report nt was reported to the state 5, three days after the incident is no indication the tate agency was immediately ent.  1/07/16, at 11:15 a.m. the restated the incident "should ately reported to her and the tate at a staff member waited until the incident. The administrator is notified, the incident was ed and investigated.  1/1/28/16, ions and/or suspicious of corted to the administrator of olicy further indicated if injury allegation of abuse is ed, if there is caregiver est immediately be reported to cartment of Health (MDH) and or immediately. The policy ternal, facility investigation of	F 2:	25			
F 226 SS=D	reports will be comp 483.12(b)(1)-(3), 48 DEVELOP/IMPLME POLICIES		F 22	26		1/17/17	

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SLIPPLIER/CLIA

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
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F 226	Continued From pa	ge 9	F 22	6	
	483.12 (b) The facility muswritten policies and	t develop and implement procedures that:			
		vent abuse, neglect, and lents and misappropriation of			
	(2) Establish policie investigate any suc	es and procedures to h allegations, and			
	(3) Include training §483.95,	as required at paragraph			
	the freedom from a requirements in § 4	and exploitation. In addition to buse, neglect, and exploitation 83.12, facilities must also heir staff that at a minimum			
		constitute abuse, neglect, isappropriation of resident hat § 483.12.			
	. , . ,	or reporting incidents of abuse, n, or the misappropriation of			
	prevention.	anagement and resident abuse			
	Based on interview	v and document review, the lement their abuse prohibition		F226- Develop Abuse Policies	
	policy and procedul allegation of abuse	re to immediately report and injuries of unknown origin r, state agency and conduct a		It is the policy of Talahi Nursing and Rehab Center to ensure that all all violations involving abuse, neglect,	eged

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F 226	Continued From pa	age 10	F 2	226			
	thorough investigation for 2 of 5 resident (R97 and R33) allegations that were reviewed.  Findings include:				exploitation or mistreatment, includinjuries of unknown source and	ing	
					misappropriation of resident proper reported immediately, but not later		
					hours after the allegation is made,	if the	
		able Adult Protection, Abuse ure dated 11/28/16, indicated			events that cause the allegation invabuse or result in bodily injury, or n		
		or suspicious of abuse must be			than 24 hours if the events that cau		
	reported to the adn	ninistrator immediately. The			allegation do not involve abuse and	do not	
		ated if injury is unexplainable,			result in serious bodily injury, to the		
		use is reported or witnessed, if neglect a report must			Administrator of the facility and to officials (including the state survey		
	immediately be rep	ported to the Minnesota			and adult protective services where		
		th (MDH) and to call the			law provides for jurisdiction in long-		
		ediately. The policy further all facility investigation of			care facilities) in accordance with s law through established procedures		
	reports will be com						
	R97's significant ch	nange MDS dated 05/18/16,			The occurrences of R97 and R33 v reviewed by the IDT, and complete		
	indicated she was	severely, cognitively impaired		7			
		ors. R97's care plan dated she had diagnoses of altered	The policy and procedure for vulne adult was reviewed and is current.			rable	
	mental status and	•			adult was reviewed and is current.		
	A Diek Menegene	at Depart dated C/0/1C at		(	All suspected vulnerable adult repo		
		nt Report, dated 6/9/16 at ed during a bath, R97 had a			reported to the DON and Administr per policy guidelines.	ator	
		f her left hand that measured 6					
		y 4 cm, and was blue, with a 1			Staff have been re-educated on the		
		ea in the center. The report 97 had no complaints of pain			vulnerable adult reporting and proc and reporting guidelines.	eaure	
	and when asked if	she bumped it, R97 smiled					
		was no indication the			DON/Administrator or designee wil		
		state agency were immediately y of known origin, nor was a			complete daily audit of progress no and risk management/incident repo		
		tion completed to determine			to ensure update immediately of all		
	the possible cause	of the injury, according to the			incidents and potential VA reports.		
	facility policy.				An audit tool of vulnerable adult rep	oorte	
	During interview or	n 12/07/16, at 11:00 a.m. the			was created and is in use to ensure		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245438	B. WING			12/08/2016	
	PROVIDER OR SUPPLIER	B CENTER		17	TREET ADDRESS, CITY, STATE, ZIP CODE 717 UNIVERSITY DRIVE SOUTHEAST AINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	administrator was use thought since I smiled after being a was probably why to The administrator the cognitively impaired reported immediate then investigated, as then investigated, as the was severely of care plan dated 03/impaired thought proceed in the difficulty verbalizing. A Incident Report donursing assistant (Nourse (RN)-B that a allegedly took placed 11/12/16, with an all immediately susper rough while grabbing morning cares on 1 and two bruises we on the top of her arcm; and one on the measuring 2 cm by bruises located on measuring 2 cm by underside measure indicated the incide agency on 11/15/16 occurred. There was administrator and sonotified of the incide of the inci	inable to recall the incident. R97 nodded her head and asked if she bumped it, this he incident was not reported. Hen stated if the resident is at the report should have been by reported to her, SA and as their policy identified.  S dated 09/06/16, indicated ognitively impaired. R33's 02/15, indicated she had rocesses and cognitive status, mer's disease, and had needs.  ated 11/15/16, indicated NA)-H reported to registered a possible abuse incident eduring the morning of leged perpetrator, whom was need. NA-H reported she was not gR33 by the forearms during 1/12/16. R33 was examined, re found on her left forearm, m measuring two cm by four underside of her arm 2 cm. There were also R33's right forearm, 4.5 cm, and the one on the d 2 cm by 2.5 cm. The report nt was reported to the state is, three days after the incident	F 2	226	timely notification and completion of investigation. This tool and the find will be reviewed weekly and at the monthly QA meetings.  Administrator, DON/designee are responsible		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	TIPLE CONSTRUCTION NG	` '	E SURVEY MPLETED
		245438	B. WING _		12/	/08/2016
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 226 F 250 SS=D	facility administrate have been" immed SA on 11/12/16, bu 11/15/16 to report t reported once she immediately report identified by their p	or stated the incident "should iately reported to her and the t a staff member waited until he incident. The administrator was notified, the incident was ed and investigated, as olicy.	F 2:			1/17/17
	social services to a practicable physical well-being of each This REQUIREME by: Based on interview facility failed to proservices to assist r for 1 of 1 residents primary physician. Findings include: R31's admission m8/26/16, indicated indicated she had a following a hospital also indicated a fol primary physician a R31's diagnosis list identified an admis infection) along wit nephropathy (kidness)	t provide medically-related ttain or maintain the highest II, mental and psychosocial resident.  NT is not met as evidenced and document review, the vide the necessary social residents in finding a physician (R31) who did not have a similar report, dated 8/19/16, been admitted to the facility II stay related to leg pain, which low up appointment with her at the facility in one week. It, dated 12/7/16, further sion diagnosis of cellulitis (skin ha history of diabetes with rey damage), heart failure, and pulmonary disease.		F250 Provision of Medically re Social Service  Talahi Nursing and Rehab Cen provide medically-related social to attain or maintain the highest practicable physical, mental an psychosocial well-being of each R31 has an established physic followed on a regular basis by physician.  Social Service has been re-edutheir role in assisting residents establish a primary care physic Health Unit Coordinator maintain audit to track date of admission for required re-visits for all new admissions.	ter does I services t d n resident. ian and is the ucated on to ian. ins an n and dates	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED
		245438	B. WING			12/	08/2016
	PROVIDER OR SUPPLIER	B CENTER		17	REET ADDRESS, CITY, STATE, ZIP CODE 717 UNIVERSITY DRIVE SOUTHEAST AINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 250	Review of physician notes identified the On 8/31/16, R31 re assessed by her properties of the conditions with mular of the conditions of	n and physician assistant (PA) following:  ceived a visit and was imary medical doctor (MD-B). that R31 needed monthly dvanced multiple comorbid tiple medications" and that lacement in skilled nursing transfer care."  sys after her last physician visit, tment to establish care with a MD-C outside the facility who enote identified MD-C would acility to "Clarify the issue con-eligibility for in-facility, MD-C declined to take R31 mending an Internal Medicine ed to place referral for the  s after her admission, R31 had ha PA-A. After assessing declined to take R31 as a complex medical history and internal Medicine Physician.  sys after she was admitted, tment with a MD-D outside the ted an assessment of R31 and y physician.  ard lacked any indication social red in assisting R31 to a primary physician while a	F 2	250	Social Services reviews audit track weekly to assure compliance.  An audit of all residents has been completed to assure physician visit compliant.  QAPI will review this audit and makerecommendations on it's continuant Social Service, Admissions Coordi Health Unit Coordinator, DON are responsible.	es are	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION IG		E SURVEY IPLETED
		245438	B. WING _		12/	08/2016
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 257 SS=B	not assessed by a she had subsequer MD-A stated it was primary physician to replacement physician to replacement physician to replacement physician and social staff were working a physician and social role in assisting R3 483.10(i)(6) COMF TEMPERATURE LI (i)(6) Comfortable a Facilities initially cemust maintain a tendegrees F. This REQUIREMED by:  Based on observative review, the facility fand maintenance s comfortable temper (R162, R165) and condayrooms reviewed.	ted he was unaware R31 was physician in September or that ally been denied care twice. The responsibility of R31's continue care until a sian was found. However, after refrom her primary physician, ected the facility's social finding R31 an appropriate  12/8/16, at 11:03 a.m. social ed residents were typically mary physician, unlike R31's ted she thought the nursing on finding R31 a new all services did not have any 1 to find a physician.  ORTABLE & SAFE	F 25		and reas. sure	1/17/17

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		E SURVEY PLETED
		245438	B. WING		<del></del>	12/0	08/2016
	PROVIDER OR SUPPLIER	B CENTER		17	REET ADDRESS, CITY, STATE, ZIP CODE 17 UNIVERSITY DRIVE SOUTHEAST AINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 257	Continued From pa	ge 15	F 2	257			
	environmental tour with maintenance s the following finding The resident dayrod dining room, was co	on 12/08/16, at 12:47 p.m. an of the facility was conducted upervisor (MS) who confirmed as:  om, located off of the main col. The temperature grees Fahrenheit (F).			Maintenance will conduct audits in random locations five times weekly period of three weeks, and make adjustments as indicated for tempe outside the parameter of 71-81 deg Audits will continue weekly for one month after this period.	for a ratures rees F.	
	at 70 degrees F.	rature in the room measured ature in the room measured at			QAPI will review audits for compliant regularly scheduled meetings and recommendations for continuance.		
	66 degrees F.	ature in the room measured at			Maintenance will be responsible.		
	findings listed above practice was for fact with concerns with pup in the morning a maintenance staff. checked resident of temperatures in over	3 p.m. MS confirmed all of the e. MS stated the usual facility staff to notify maintenance paper slips, which were picked as needed by the Further, MS stated he had not a month because he did not as working on getting around		S			
F 280 SS=D	but was not provide 483.10(c)(2)(i-ii,iv,v	naintenance was requested, d during the survey. )(3),483.21(b)(2) RIGHT TO NNING CARE-REVISE CP	F 2	280			1/17/17
	and implementation	articipate in the development of his or her person-centered ng but not limited to:					
		cipate in the planning process, o identify individuals or roles to					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG		E SURVEY MPLETED
		245438	B. WING _		12	/08/2016
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 280	request meetings a revisions to the per (ii) The right to part expected goals and amount, frequency, other factors related plan of care.  (iv) The right to recincluded in the plan (v) The right to see right to sign after si of care.  (c)(3) The facility shright to participate i shall support the replanning process m (i) Facilitate the incresident representation (iii) Include an assestrengths and need (iiii) Incorporate the cultural preferences 483.21  (b) Comprehensive (2) A comprehensive (2) A comprehensive (3)	planning process, the right to and the right to request son-centered plan of care. Icipate in establishing the doutcomes of care, the type, and duration of care, and any dout to the effectiveness of the leive the services and/or items of care.  The care plan, including the gnificant changes to the plan all inform the resident of the notice in this or her treatment and sident in this right. The leust-leusion of the resident and/or active.  In sement of the resident and and in developing goals of care.  Care Plans  The care plan must be- The days after completion of	F 28			

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245438	B. WING		12/08/2016
	PROVIDER OR SUPPLIER  NURSING AND REHA	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLÉTION
F 280	Continued From pa	nge 17	F 280		
	(ii) Prepared by an includes but is not I	interdisciplinary team, that imited to			
	(A) The attending p	physician.			
	(B) A registered nur resident.	rse with responsibility for the			
	(C) A nurse aide wi resident.	th responsibility for the			
	(D) A member of fo	od and nutrition services staff.			
	the resident and the An explanation must medical record if the and their resident re	racticable, the participation of e resident's representative(s). It be included in a resident's re participation of the resident representative is determined the development of the	1		
		tte staff or professionals in mined by the resident's needs the resident.			
	team after each ass comprehensive and assessments. This REQUIREMEI	revised by the interdisciplinary sessment, including both the diquarterly review			
	review, the facility f	tion, interview and document ailed to update the resident s with new interventions after a		F280-Right to Participate in Plann Care Plans	ing
		completed for 1 of 2 residents		It is the policy of Talahi Nursing and Rehab Cento to establish a care plant residents which accurately refle	lan for
	Findings include:			needs and strengths and guides st	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		245438	B. WING		12/0	8/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304	1 12/0	0/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 280	dated 12/8/16, incl failure, anxiety disc admission Minimum 11/22/16 indicated The care area ass 11/22/16 identified shortness of breath and balance. The working with theral endurance, was must be assist with mobile During observation was seated in her room door. R92 woxygen tubing to the anasal cannula in a cord, which lead movement-detecting the back of the whole Review of an Investing indicated R92 had room on 11/20/16. added an intervent personal, movement R92 when in whee R92 when in whee R92 when in whee R91 indicated R92 indicated R93	as identified on the face sheet uded chronic respiratory order and weakness. R92's in Data Set (MDS) dated moderately impaired cognition. essment (CAA) for falls dated R92 was at risk for falls due to n with activity, unsteady gait CAA also indicated R92 was by for strengthening and aking progress, and staff were lity and transfers.  In on 12/06/16 at 2:22 p.m., R92 wheel chair just outside her ore shoes and socks, had he right of the wheel chair, with place. Clipped to her shirt was directly to a TABS (a personal, and safety) alarm, fastened to eel chair.  Stigation Report dated 11/22/16 an unwitnessed fall in her The interdisciplinary team ion to place a TABS (a int-detecting safety) alarm for	F 280	providing resident care. The policy been reviewed and is current.  R92 does not have a TABS alarm. care plan, and nurse Aide care she accurate.  Education was completed for direct staff on following the care plan.  All care plans are reviewed in conjuith the RAI process.  Audits of care provided, per the decare plan, will be conducted on fiver random residents weekly for two mandations for continuance poons or designee is responsible.	. The eets are ct care junction eveloped e nonths.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG		E SURVEY PLETED
		245438	B. WING _		12/0	08/2016
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 280	identified R92 requimoderate fall risk, wand had a regular of R92's fall intervention.  During an interview nursing assistant (Nand used her nursing sheet, NA-I said the alarm, "but I know [alarm on." NA-I staresidents care plans meetings, but it wook care plan, especiall.  During interview on director of nursing (care plan in the resupdated, as well as DON stated the unity and it was a matter "completed and upon A facility policy titled indicated it is the policy all residents have a reflects their needs staff in providing residented an interdisfor the development.	ing aide care sheets, undated, red stand by assist, was a was to bet toiled every 2 hours, iet. The sheet did not include on to use the TABS alarm.  on 12/8/16 at 10:02 a.m., IA)-I stated she always carried and sheet. After reviewing the ere was nothing about R92's R92] is supposed to have the atted she learns of changes to sat the change of shift ald be important to know the y if you help any new resident.  12/8/16 at 10:15 a.m. the DON) stated R92's working ident's chart should have been the aide cares sheets. The tranagers were responsible, of getting that task dated."  If Careplan revised 3/25/16, olicy of Talahi Care Center that Plan of Care which accurately and strengths, and guides sident care. The policy further sciplinary team is responsible to f the care plan and nursing	F 28			
F 281 SS=D	PROFESSIONAL S	VICES PROVIDED MEET TANDARDS	F 28	11		1/17/17
	(b)(3) Comprehens	ve Care Plans				

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION  NG		E SURVEY PLETED
		245438	B. WING		12/0	08/2016
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 1717 UNIVERSITY DRIVE SOUTHEAS SAINT CLOUD, MN 56304	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 281		led or arranged by the facility,	F 2	81		
	(i) Meet professional This REQUIREMENT by: Based on interview facility failed to devent the needs of a of 1 newly admitted risk for pressure ulderisk for	essment, dated 12/01/16, occasionally moist skin, was limited mobility and had with friction and shear. The ed a score of 14, which at moderate risk for		F281- Services Provided to Professional Needs  It is the policy of Talahi Nursi Rehab Center to establish a care plan within 24 hours of a R94 initial temporary care plaestablish on admission. This was reviewed for ADL's toilet and repositioning needs and and accurate.  All care plans are reviewed in with RAI process.  Education completed to all distaff on following the care plaimplementing accurate and tiplans.  All temporary care plans have reviewed to ensure that they residents needs.  Audits of care provided, per to care plan, will be conducted random residents weekly for Audit of all temporary care plan meets.	ing and temporary admission.  an was care planting needs is current  n conjunction  irect care an and imely care  the developed on five two months.  lans to assure	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		E SURVEY PLETED
		245438	B. WING		12/	08/2016
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 281	and that she was s provide cares. NAsomeone to help hi 8:30 a.m., and said At 8:34 a.m. NA-E pad that was mode was incontinent of a R94's entire perial (damage or remove skin). NA-E stated and applied periore stated he started affirst time during his R94. NA-E said he last changed.  During interview 12 registered nurse (Prepositioned every risk" for skin breake should have been of A facility policy titled indicated "It is the path that all residents he accurately reflects guides staff in proving policy further indicated admission, a tempo which will accurate strengths, and guide care.	ated he was checking on R94, supposed to have two staff to be stated he was going to find m. NA-E returned alone at the was unable to find help. The was red and excoriated the part of the surface of the R94's bottom was very red, was to the area. NA-E then to 6:00 a.m. and this was the shift he had provided cares to the did not know when R94 was a complete the was always at the same to the was a complete the was a staff in providing resident needs and es staff in providing resident RVICES BY QUALIFIED	F 281	residents needs will be conducted months.  Repositioning and toileting audits we conducted on five random resident weekly for the next two months.  QAPI committee will review all audicompliance at regularly scheduled meetings and make recommendaticontinuance.  DON or designee is responsible	vill be s its for	1/17/17
SS=E	(b)(3) Comprehens					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION		SURVEY PLETED
		245438	B. WING		12/0	8/2016
	PROVIDER OR SUPPLIER	B CENTER	-	STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	as outlined by the omust-  (ii) Be provided by accordance with eacare. This REQUIREME by: Based on observareview, the facility of care was implement R49, R94 and R87 dependent on staff (ADLs).  Findings include: BATHING R41's quarterly Mir 11/21/16, identified cognitively impaired from facility staff for (ADL)'s. In addition ADL's during the MR41's plan of care, had an identified prelated to her (R41 plan identified R41 of 1 with ADL's and once a week as red the care plan noted.	age 22 comprehensive care plan, qualified persons in ach resident's written plan of NT is not met as evidenced tion, interview, and document failed to ensure the plan of nted for 4 of 5 residents (R41, ) reviewed who were for activities of daily living d and required total assistance r activities of daily living l, R41 had no rejection of IDS assessment period.  dated 10/06/16, noted R41 roblem for ADL self-care deficit 's) dementia. Further, the care required extensive assistance d was to receive a tub bath quested by R41. In addition, d R41 was to be provided a la a full bath could not be	F 282	,	care is nd bed e nd wer for ed	
	12:41 p.m. R41 sta weekly scheduled	with R41 on 12/05/16, at atted she had not received bath on a "regular basis" and cause she required assistance		R94 care plan has been reviewed a updated to reflect current turning, to and repositioning needs. The nurse care sheet has been updated.	ileting	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION		E SURVEY PLETED
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304	, , , , , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 282	from facility staff w R41's Body Audit F received a tub bath 10/13/16, and 10/5 medical record, the had rejected ADL's through 12/05/16.  During interview or nursing assistant (s should be docume the bath book. Furi unaware of R41 re was a "tough one"  When interviewed registered nurse (F receiving at least of her care plan. Furt baths, "were not ha audit forms.  During interview or director of nursing residents in the fact baths as directed to  ASSISIT DEVICES R49's quarterly ME R49 was severely s supervision and se  R49's care plan da resident requires n by staff to eat. Cut cup half full and co	Form identified R41 had a on 11/21/16, 11/10/16, 1/16. Upon review of R41' sere was no indication that R41 with bathing from 10/05/16 on 12/07/16, at 6:07 a.m.  NA)-J stated all of R41's baths need on the body audit form in ther, NA-J stated she was fusing a bath in the past, but to bathe.  On 12/07/16, at 10:16 a.m.  RN)-D stated R41 should be one bath a week according to her RN-D stated R41's ppening "according to the body audit form in the past, but to bathe.  On 12/07/16, at 11:26 a.m. with (DON) stated she was aware cility were not receiving their by the care plan.	F 282	Staff have been re-educated on turning, toileting and repositioning. The care plan of R87 was review updated to include direction to spositioning and nurse aide shee accurate.  Staff were re-educated on follow care plan.  Audits of care provided, per the care plan, will be conducted on random residents weekly for two QAPI committee will review all a compliance at regularly schedul meetings and make recommend continuance.  DON/designee is responsible.	ng needs.  wed and staff for t is  ving the  developed five o months.  audits for ed	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION  NG		TE SURVEY MPLETED
		245438	B. WING		12	/08/2016
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP 1717 UNIVERSITY DRIVE SOUTH SAINT CLOUD, MN 56304	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 282	During observation nursing assistant (Natray along with a cuno ice in the coffee from the cup.  During interview 12 stated she was not they provide to kee Review of Incident a.m., indicated R49 breakfast meal and Immediate interven liquid half full, and a temperature; and s in east kitchen to real Although R49 received a received an addition During interview 12	12/07/2016, at 12:34 p.m. NA)-G provided R49 her lunch up of coffee 3/4 full. There was and visible steam was coming //07/16, at 12:40 p.m. NA-G aware of any interventions p her coffee luke warm. report dated 7/27/16 at 8:30 was given coffee prior to R49 spilled coffee on her lap. tions included: fill coffee/hot add ice cubes to cool to room ignage placed by coffee carafe emind of new intervention. ved a injury from hot coffee entions were not followed to	F2			
	looking at her care in it.  INCONTINENCE R94's Admission R had dementia and I Continence Evalua indicated she was i was unknown, unal was not motivated	m by adding water, and after plan it should have ice placed ecord undated indicated she neurological disease. A facility tion form dated 12/06/16, ncontinent of bladder, onset ble to sit on the toileted and to toilet.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY COMPLETED	
		245438	B. WING _		12	/08/2016	
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP C 1717 UNIVERSITY DRIVE SOUTHEA SAINT CLOUD, MN 56304	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 282	incontinent of bower ounds (every two indicated R94 was to reposition herse R94's nursing assisinstructed staff to thours.  During continuous 6:00 a.m. to 8:34 a R94 was lying in her nightgown on. observed during the assistant (NA)-E lowalked by. At 8:13 room stated he waprovide R94 with a re-entered the roor which was modera a small bowel mov was red and excord of the surface of the bottom was very rethe area. NA-E stated this was the fir provided cares to Fknow when R94 was During interview 12 nurse (RN)-C stated and should be toiled to her care plan.  FALL INTERVENT R87's admission M	2/1/16, indicated she was el and bladder and toilet on hours). The care plan high risk for falls, was unable lif.  Stant care sheet, undated, oilet the resident every two observation on 12/07/16, from .m. (2 hours and 34 minutes) er bed on her right side with There was no staff for R94 is time. A 7:52 a.m. nursing oked into R94's room and a.m. NA-E entered R94's schecking on R94, but did not my cares. At 8:34 a.m. NA-E m and removed R94's pad tely soaked with urine, and had ement. R94's entire peri- area liated (damage or remove part e skin). NA-E stated her ed, and applied peri cream to ated he started at 6:00 a.m. set time during his shift he had R94. NA-E said he did not as last changed.  2/07/16, at 1:10 p.m. registered at R94 was incontinent of urine sted every two hours according	F 28	32			
		R87 was mildly, cognitively					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245438	B. WING		12/	08/2016
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 282	was at risk for falls activities of daily liv R87's care plan, da high risk for falls ar "Dycem non-slip mat all times while recare plan did not dicushion to the wheel During observation was seated in his wand no Dycem was During the evening again observed seat Dye was present in observation on 12/8 seated in his wheel Dycem was observed Dycem was observed Dycem was observed During interview on assistant (NA)-F standard Dycem in his wheel unaware of dycem was needed in R87 During interview on director of nursing of were communicate meetings. The DO	heelchair for locomotion, and and dependent upon staff for ing.  Ited 11/8/16 identified R87 at ad included interventions for aterial to remain in wheelchair sident is up in chair." R87's rect staff to fasten the wedge elchair.  On 12/7/16, at 1:36 p.m., R87 wheelchair while eating lunch, observed in the wheelchair, meal at 4:48 p.m., R87 was ated in his wheelchair, and no the wheelchair. During 8/16, at 9:09 a.m. R87 was chair during breakfast, and no ed in R87's wheelchair.  12/8/16, at 9:16 a.m. nursing ated R87 did not have any lack at the was being a fall intervention, or 's wheel chair.  12/8/16 at 11:13 a.m., the (DON) stated fall interventions d to staff daily at morning N further stated staff were laber the interventions, and be	F 282			
F 312 SS=D	care plans was req	mplementation of resident uested, but not provided. CARE PROVIDED FOR IDENTS	F 312			1/17/17

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	PLE CONSTRUCTION (:	X3) DATE SURVEY COMPLETED
		245438	B. WING		12/08/2016
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 312	(a)(2) A resident whactivities of daily live services to maintain personal and oral had the personal and the personal and the personal	no is unable to carry out ing receives the necessary in good nutrition, grooming, and lygiene.  NT is not met as evidenced stion, interview, and document ailed to provide baths and stance for 2 of 3 residents and that were dependent upon a faily living (ADLs).  Immum Data Set (MDS) dated R41 was moderately and required total assistance on, R41 had no rejection of DS assessment period.  Idated 10/06/16, noted R41 had m for ADL self-care deficit so dementia. Further, the care required an extensive with ADL's and was to receive week as requested by R41. In lan noted R41 was to be bath when a full bath could not with R41 on 12/05/16, at ted she had not received baths on a "regular basis "and cause she required assistance"	F 312	312-ADL Care Provided For Depend Residents.  Talahi Nursing and Rehab Center do provide residents whom are unable to carry out activities of daily living with services to maintain personal hygien and timely toileting assistance.  R41 and R49 were assessed for anoplans reviewed for bathing and toilet needs.  Education was provided to staff on following the care plan and providing according to the care plan.  Education was provided on completi bathing sheets.  Audits of care provided, per the deverandom residents weekly for two modulations of the care plan, will be conducted on five random residents weekly for two modulations and make recommendation continuance.	es co ee, d care ing care on of eloped nths.
		orm identified R41 had on 11/21/16, 11/10/16,		DON/designee is responsible	

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION  NG		TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP 1717 UNIVERSITY DRIVE SOUTHE SAINT CLOUD, MN 56304	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 312	10/13/16, and 10/5 medical record, the R41 rejecting ADL's 12/05/16.  During interview or nursing assistant (I should be documenthe bath book. Furtunaware of R41 relewas a "tuff one "to When interviewed registered nurse (Freceiving at least of R41's baths "were the body audit form completed.  During interview or director of nursing residents dependenceiving their bath Review of a facility 10/2013, identified, bath per care plan.  R94's Admission Radmitted 12/01/16, neurological diseas and an admission I not yet completed.  R94's Individual Redated 12/1/16, indicated 12/16, i	in 12/07/16, at 6:07 a.m.  NA)-J, stated all of R41's baths inted on the body audit form in ther, NA-J stated she was fusing a bath in the past and bath.  In 12/07/16, at 10:16 a.m. IN)-D stated R41 should be ne bath a week. RN-D stated not happening "according to its, and should have been in 12/07/16, at 11:26 a.m. with (DON) stated she was aware in the upon staff, were not so.  In 12/07/16, at 11:26 a.m. with (DON) stated she was aware in the upon staff, were not so.  In 12/07/16, at 11:26 a.m. with (DON) stated she was aware in the upon staff, were not so.  In 12/07/16, at 11:26 a.m. with (DON) stated she was aware in the upon staff, were not so.  In 12/07/16, at 11:26 a.m. with (DON) stated she was aware in the upon staff, were not so.  In 12/07/16, at 11:26 a.m. with (DON) stated she was aware in the upon staff, were not so.	F3	12		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION		E SURVEY PLETED
		245438	B. WING		12/	08/2016
	ROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 312	hours.  A Continence Evaluation 12/06/16, indicated bladder and wore a further indicted it was urge to void and did to buring continuous of 6:00 a.m. to 8:34 a. R94 was lying in he her nightgown on. observed during this assistant (NA)-E los walked by. At 8:13 room stated he was provide R94 any care-entered the room which was moderated a small bowel move was red and excoris of the surface of the bottom was very rethe area. NA-E stated this was the first provided cares to Renow when R94 was buring interview 12 stated R94 was incompleted.	attion assessment dated R94 was incontinent of brief. The assessment as unknown if R94 had and not use the toilet.  Observation on 12/07/16, from m. (2 hours and 34 minutes) or bed on her right side with There was no staff for R94 stime. A 7:52 a.m. nursing oked into R94's room and a.m. NA-E entered R94's checking on R94, but did not res. At 8:34 a.m. NA-E and removed R94's pad ely soaked with urine, and had ement. R94's entire peri- area ated (damage or remove part e skin). NA-E stated her d, and applied peri cream to ted he started at 6:00 a.m. at time during his shift he had 194. NA-E said he did not its last changed.	F 312			
F 314 SS=D	reported (R94) was risk for skin breakd and changed every 483.25(b)(1) TREA PREVENT/HEAL P	dependent upon staff and at own, and should be checked two hours. TMENT/SVCS TO	F 314	4		1/17/17
	(b) Skin Integrity -					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION  NG		E SURVEY PLETED
		245438	B. WING _		12/	08/2016
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIF 1717 UNIVERSITY DRIVE SOUTH SAINT CLOUD, MN 56304	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ( (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 314	(i) A resident receive professional standar pressure ulcers and ulcers unless the irredemonstrates that  (ii) A resident with precessary treatme professional standar healing, prevent inform developing. This REQUIREME by:  Based on observative review the facility facts assistance for toile reduce the risk of pressure ulcers.  Findings include:  R94's undated Administration of the standard pressure ulcers.	s. Based on the sessment of a resident, the	F3		ent Pressure Center does th professional revent pressure	
	diagnoses of demedisease in which that the protective coadmission Minimur completed.  A Braden Skin assepressure ulcer risk R94 had occasional	entia and multiple sclerosis (A the immune system eats away overing of nerves). R94's m Data Set (MDS) was not the essment (scale for predicting ally moist skin, was bed fast,		R94 care plan was review current.  All residents identified as pressure ulcer developme reviewed to assure accuraensure they are receiving care.	at risk for Int have been acy and to appropriate	
	nad very limited mo	obility, with a potential problem		The policy for prevention a	and treatment of	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		245438	B. WING		12/0	8/2016
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETION DATE
F 314	score of 14 which is risk for developing.  R94's Individual Recare plan) dated 12 incontinent of bowe toileted on rounds. indicate she was at During continuous 6:00 a.m. to 8:34 a R94 was lying in he her nightgown on. observed during this assistant (NA)-E lowalked by. At 8:13 room and said he would not provide R94 and re-entered the room which was moderated a small bowel move was red and excort of the surface of the bottom was very rethe area. NA-E state and this was the fir provided cares to Feath which was moderated and this was the fir provided cares to Feath was the fir provided cares to Feath was red and at risk for be checked/changer repositioned during A facility policy "Presentation of the surface of the surf	ar. The assessment had a ndicated R94 was at moderate a pressure ulcer.  Pesident Care Plan (temporary 2/1/16, indicated R94 was el and bladder and was to be R94's care plan did not a risk for pressure ulcers.  Observation on 12/07/16, from a.m. (2 hours and 34 minutes) er bed on her right side with There was no staff for R94 is time. At 7:52 a.m. nursing oked into R94's room and a.m. NA-E entered R94's was checking on R94, but did by cares. At 8:34 a.m. NA-E and removed R94's pad tely soaked with urine, and had ement. R94's entire peri- area ated (damage or remove part e skin). NA-E stated her and applied peri cream to ated he started at 6:00 a.m. st time during his shift he had R94. NA-E said he did not as last changed.  Poor/16, at 1:10 p.m. registered of R94 was incontinent of or skin breakdown. She should ed every two hours and	F 314	pressure ulcers/skin breakdown we reviewed and is current.  The policy for evaluation of skin ristreviewed and is current.  Education was provided to clinical the policy and procedure for prever pressure ulcers/skin breakdown.  Audits of care provided, per develocate plan, will be conducted on fiver random residents weekly for two marker which the IDT will review and further recommendations.  QAPI committee will review all audicompliance at regularly scheduled meetings and make recommendation continuance.  DON/designee is responsible	sk was staff on ention of oped e nonths. d make	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  IG		E SURVEY MPLETED
		245438	B. WING _		12/	08/2016
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 314	skin integrity, and p preventative measu appropriate treatme according standard	orcrease the risk for impaired bressure ulcers, to implement ures, and to provide ent modalities for wounds s of care."	F 31			1/17/17
F 315 SS=D	(e) Incontinence. (1) The facility mus continent of bladde receives services a continence unless to recomes such that to maintain.  (2) For a resident who on the resident's confacility must ensure (i) A resident who e indwelling catheter resident's clinical or catheterization was (ii) A resident who e indwelling catheter is assessed for remas possible unless demonstrates that of and (iii) A resident who receives appropriate prevent urinary tracecontinence to the experience.	t ensure that resident who is and bowel on admission and assistance to maintain his or her clinical condition is not continence is not possible with urinary incontinence, based omprehensive assessment, the othat- enters the facility without an is not catheterized unless the condition demonstrates that necessary; enters the facility with an or subsequently receives one noval of the catheter as soon the resident's clinical condition catheterization is necessary is incontinent of bladder to the treatment and services to set infections and to restore	F 31	5		1/17/17

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					OATE SURVEY COMPLETED		
	245438				12/0	12/08/2016	
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 1717 UNIVERSITY DRIVE SOUTHEAS SAINT CLOUD, MN 56304	DE .		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 315	on the resident's confacility must ensure incontinent of bowe treatment and serve bowel function as process. This REQUIREME by:  Based on interview facility failed to conchange in continent (R38) reviewed for Findings include:  R38's admission Mo8/04/16, indicated urine. The quarterly indicated R38 was (7 or more episode one episode of conassessment (CAA) was on a diuretic (Lassistance with toil identified R38 did redue to cognitive in toilet R38 every two R38's care plan darequired extensive A Bladder 7 Day Dethru 8/4/16, indicated of urine. A subseq 10/26/16 thru 11/1/incontinent of urine change in status from August 2016.	comprehensive assessment, the enthal a resident who is that a resident who is the receives appropriate vices to restore as much normal possible.  Nor is not met as evidenced who, and document review, the inprehensively reassess a line status for 1 of 3 residents urinary incontinence.  In the inprehensively reassess a line status for 1 of 3 residents urinary incontinence.  It is not met as evidenced who are status for 1 of 3 residents urinary incontinence.  It is not met as evidenced who are status for 1 of 3 residents urinary incontinence.  It is not met as evidenced at the incontinence of 3 residents urinary incontinence.  It is not met as evidenced at the incontinence of 3 residents urinary incontinence.  It is not met as evidenced who are status for 1 of 3 residents urinary incontinence.  It is not met as evidenced who are status for 1 of 3 residents urinary incontinence.	F 31	F315-No catheter, Prevent UBladder  Talahi Nursing and Rehab Ceprovides appropriate treatments services to residents to restort to the extent possible.  The assessment tool for evaluarinary continence has been in is current.  R38 has completed a seven or reassessment for bladder contine care plan and care assess have been updated to reflect status.  Residents identified as incontreviewed to ensure they are maccurate assessments, and a services as indicated by those assessments.  The bowel and bladder assess and procedure has been reviewed to ensure they are maccurate assessments.  The bowel and bladder assessments and procedure has been reviewed to ensure they are maccurated assessments.	enter nt and re continence uating reviewed and day ntinence, and sment sheet the current cinent were eceiving appropriate e esment policy ewed and is		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	245438	B. WING		12/08/2016		
	B CENTER		1	717 UNIVERSITY DRIVE SOUTHEAST		
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
indicated R38 did n without incontinence to toilet and was for assessment on 11/continence was left from continent to from continent or property of there were no channels eliminate or property of the peliminate of the peli	ot always void appropriately e, was independent, but slow rgetful. This portion of R38's 1/16 to indicate changes in blank. Although R38 went equently incontinent of urine, ges to R38's interventions to event the incontinence.  1/06/16, at 3:40 p.m. R38's 1/10-C stated R38 wore a pad  1/10/16, at 1:45 p.m. nursing esisted R38 to toilet and R38 ine.  1/07/16, at 1:19 p.m. registered d R38 was continent of urine, ently incontinent of urine. Impleted the MDS according any documentation, and the were responsible for essment and following through D stated there were no R38's toileting program and the f nursing (ADON) should have ended.  1/10/16, R1/16, R1/1		5	week for three weeks on bowel and bladder assessments, and appropr treatments and services indicated those assessments.  QAPI committee will review all aud compliance at regularly scheduled	iate by ts for	
403.23(u)(1)(2)(f1)(	1)-(3) FREE OF ACCIDENT	гз	23			1/17/17
	PROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR L  Continued From pa indicated R38 did n without incontinence to toilet and was for assessment on 11/ continence was left from continent to free there were no chan help eliminate or pr  During interview 12 family member (FM and dribbled urine.  During observation assistant (NA)-F as was continent of ur  During interview 12 nurse (RN)-D state but now was freque RN-D stated she co to the Bladder 7-Da nurses on the floor completing the assi with changes. RN- changes made to F assistant director of made changes if ne  A facility policy titled Assessment will en bowel or bladder in appropriate treatme much normal bowe possible.	PROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 34 indicated R38 did not always void appropriately without incontinence, was independent, but slow to toilet and was forgetful. This portion of R38's assessment on 11/1/16 to indicate changes in continence was left blank. Although R38 went from continent to frequently incontinent of urine, there were no changes to R38's interventions to help eliminate or prevent the incontinence.  During interview 12/06/16, at 3:40 p.m. R38's family member (FM)-C stated R38 wore a padand dribbled urine.  During observation 12/08/16, at 1:45 p.m. nursing assistant (NA)-F assisted R38 to toilet and R38 was continent of urine.  During interview 12/07/16, at 1:19 p.m. registered nurse (RN)-D stated R38 was continent of urine, but now was frequently incontinent of urine, but now was frequently incontinent of urine.  RN-D stated she completed the MDS according to the Bladder 7-Day documentation, and the nurses on the floor were responsible for completing the assessment and following through with changes. RN-D stated there were no changes made to R38's toileting program and the assistant director of nursing (ADON) should have made changes if needed.  A facility policy titled, "Bowel and Bladder Assessment policy and procedure," effective 08/2016, indicated the residents' comprehensive assessment will ensure that each resident, with bowel or bladder incontinence, will receive appropriate treatment and services to restore as much normal bowel or bladder functioning as	PROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 34 indicated R38 did not always void appropriately without incontinence, was independent, but slow to toilet and was forgetful. This portion of R38's assessment on 11/1/16 to indicate changes in continence was left blank. 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ROVIDER OR SUPPLIER  10 PROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (ICAH) DEFICIENCY WIST BE PRECEDED BY PILL (REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 34  Indicated R38 did not always void appropriately without incontinence, was independent, but slow to toilet and was forgetful. This portion of R38's assessment of 11/1/16 to indicate changes in continence was left blank. Although R38 went from continent to frequently incommence, there were no changes to B38's interventions to help eliminate or prevent the incontinence.  During interview 12/06/16, at 3:40 p.m. R38's family member (FM)-C stated R38 wore a pad and dribbled urine.  During observation 12/08/16, at 1:19 p.m. registered nurse (RN)-D stated R38 was continent of urine, but now was frequently incontinent of urine, but now was frequently incomment of urine.  RN-D stated R38 was continent of urine, but now was frequently incomment of urine.  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RN-D stated R38 wore and the assessment policy and procedure, "effective 03/2016, indicated the residents' comprehensive assessment policy and procedure," effective 03/2016, indicated the residents' comprehensive assessment policy and procedure, "effective objects, indicated the residents comprehensive assessment policy and procedure," effective objects, indicated the residents comprehensive assessment policy and procedure, "effective objects, indicated the residents comprehensive assessment policy and procedure," effective objects of the procedure appropriate treatment and services to	A BUILDING COM  245438  B. WIND  3TREET ADDRESS, CITY, STATE, ZIP CODE  177 UNIVERSITY DRIVE SOUTHEAST  SUMMARY STATEMENT OF DEFICIENCIES (EACH OBECIDENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  COntinued From page 34 indicated R38 did not always void appropriately without incontinence, was independent, but slow to toilet and was forgetful. 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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
		<b>245438</b> B. WING		12/	12/08/2016		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304	DE .		
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F 323 SS=E	(d) Accidents. The facility must e  (1) The resident end from accident haza  (2) Each resident in and assistance de  (n) - Bed Rails. The appropriate alternated bed rail. If a bed of must ensure corresident ensure corresident ensure and the following electric the following electron bed rails prious (2) Review the risk the resident or resinformed consent (3) Ensure that the appropriate for the This REQUIREME by:  Based on observative review, the facility supervision and in to prevent accident (R87, R49, R75, Raddition, the facility supervision, the facility addition, the facility must be suppropriated for the the facility supervision, and in the facility supervision, the facility addition, the facility addition, the facility must be suppressed to the facility supervision, the facility addition, the facility and the facility supervision, the facility addition, the facility and the facility supervision, the facility addition, the facility and the facility supervision, the facility addition, the facility and	nsure that - nvironment remains as free ards as is possible; and receives adequate supervision vices to prevent accidents. The facility must attempt to use atives prior to installing a side or or side rail is used, the facility ct installation, use, and ad rails, including but not limited ements.  Ident for risk of entrapment	F3	F323 Free of Accidents  Talahi Nursing and Rehab Cereach resident receives adequasupervision to prevent accider	ate nts.		
		for 1 of 20 residents (R3) who		current.  Fall prevention policy was revi			

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F 323	Findings include:  FALLS R87's admission M 10/4/16, identified I used a wheelchair for falls.  R87's admission C dated 10/10/16, ide related to unsteady The CAA also indic maintaining balanc would "Lean back a legs."  Facility Incident Re to 11/26/16, identifit facility since admis 10/22/16, indicated slid out of R87's wh the floor. The repor sheet) was placed to the care plan.  R87's care plan, da was a high risk for the intervention "Dy remain in wheelcha up in chair." R87's recieved a new wh fall prevention.  During observation was seated in his w and no dycem was During the evening again observed sea	dinimum Data Set (MDS), dated R87 was cognitively impaired, for locomotion, and was at risk are Area Assessment (CAA), entified R87 was at risk for falls agait and impaired balance. The stated R87 had difficulty ewhile sitting, indicating R87 at times he will straighten his apports, reviewed from 10/9/16 ed R87 had seven falls in the sion. An incident report, dated R87's wheelchair cushion had neelchair causing him to fall to at indicated Dycem (non skid in R87's wheelchair and added at at all time while resident is care plan also indicated he eelchair cushion to assist with on 12/7/16, at 1:36 p.m., R87 wheelchair while eating lunch. Observed in the wheelchair. meal at 4:48 p.m., R87 was ated in his wheelchair. During	F 32	current.  R49 care plan was reviewed a current.  R75 care plan was reviewed a current.  R3 side rails were secured at survey, and maintenance che retails daily to assure they are Staff were re-educated on appinterventions to reduce the rist to resident altercations, falls at the care plan to prevent accid Maintenance performs three raudits weekly for three weeks side rails are secure.  All beds with rails have been densure they are tightly secure Dietary conducts three audits three weeks to assure dietary are being followed.  QAPI committee will review at compliance at regularly sched meetings and make recomme continuance.  DON/designee, Maintenance Dietary Director are responsible.	and is  time of ecks these es secure.  propriate sk of resident and following dents.  random sto assure  checked to ed.  weekly for guidelines  Il audits for duled endations for	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245438	B. WING		12	/08/2016	
	PROVIDER OR SUPPLIER  NURSING AND REHA	B CENTER		STREET ADDRESS, CITY, STATE, Z 1717 UNIVERSITY DRIVE SOUTH SAINT CLOUD, MN 56304	IP CODE		
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F 323	observation on 12/8 seated in his wheel dycem was observed.  During interview on assistant (NA)-F stain his wheelchair. Nof dycem being a fafor R87's wheel chart of the dycem being a fagor R87's wheel chart of the dycem recieved the dycem recieved the new was provided a non slip plan had not been advocem.  During interview on occupational therapt the dycem in his was cushion did not prosurface.  During interview on director of nursing were communicate meetings. The DO expected to rememing them.  A facility policy titled 9/1/16, directed all would be assessed interventions on the were to be implement.	3/16, at 9:09 a.m. R87 was chair during breakfast, and no ed in R87's wheelchair.  12/8/16, at 9:16 a.m. nursing ated R87 did not have dycem IA-F stated she was unaware all intervention, or was needed air.  12/8/16, at 9:38 a.m., and the surface R87 molonger in his wheelchair once R87 meelchair cushion, which surface. RN-C stated the care revised to discontinue the revised to discontinue the revised an appropriate non slip  12/8/16 at 11:13 a.m., the (DON) stated fall interventions d to staff daily at morning N further stated staff were aber the interventions, and be discontinue the revised to discontinue the revised to staff daily at morning N further stated staff were aber the interventions, and be discontinue the revised staff were aber the intervention, and be discontinue the revised staff were aber the intervention, and be discontinue the revised staff were aber the intervention, and be discontinue the revised staff were aber the intervention, and be discontinue the revised staff were aber the intervention, and be discontinue the revised staff were aber the intervention, and be discontinue the revised staff were aber the intervention, and be discontinue the revised staff were aber the intervention, and be discontinue the revised staff were aber the intervention, and be discontinue the revised staff were aber the intervention, and be discontinue the revised staff were aber the intervention and assessment and assessment and assessment and assessment and assessment and assessment are revised to discontinue the revised staff were aber the revi	F3	23			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245438	B. WING		12	/08/2016	
	PROVIDER OR SUPPLIER  NURSING AND REHA	B CENTER		STREET ADDRESS, CITY, STATE, ZIF 1717 UNIVERSITY DRIVE SOUTH SAINT CLOUD, MN 56304	CODE		
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F 323	R49 was severely of needed supervision  A Progress Note daindicated R49 had moving cup to her ileft arm and lap. R left arm approximareddened area on I 3".  A Risk Managemer indicated "Client waroom for breakfast. prior to getting meabreakfast client graher mouth and accider left arm and lapin place for staff to half full and add iceprior to serving, signoffee carafes in eaintervention.  R49's care plan dairesident required a cueing by staff to ecoffee fill cup half-fiplacing at the table.  During observation nursing assistant (Nunch tray along with There was no ice ir observed coming from the place of the pl	age 38 cognitively impaired, and and set up with eating.  ated 7/27/16, at 11:34 a.m. picked up the coffee cup, was mouth spilled the hot coffee on eddened area appeared on tely "5' (inches) by 2", lap was eft leg 8" by 4", right leg 7" by at report dated 7/27/16, as sitting at table in dinning Client was given beverages al. While client was waiting for bbed the cup, moved it toward identally spilled her coffee on b." Writer placed intervention fill coffee/hot liquid containers accubes to cool to room temp anage placed in front of the ast kitchen to remind staff of ted 08/10/16, indicated "This mechanical soft diet and at. Cut up food as needed, ull and cool with ice prior to coffee should be luke-warm."  12/07/2016, at 12:34 p.m., NA)-G provided R49 with her that cup of coffee 3/4 full. In the coffee, and steam was from the top of the coffee cup.  12/07/16, at 12:40 p.m. NA-G aware of any interventions p R49's coffee luke warm.	F3	23			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		245438	B. WING		12/08/2016	
NAME OF PROVIDER OR SUPPLIER  TALAHI NURSING AND REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304		
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F 323	registered nurse (F should be luke war then stated R49's obe placed in her cuwater. RN-B thoughad changed.  RESIDENT TO RE R75's quarterly Mir 11/5/16, indicated simpaired and depression of restaff, related to der disturbance. The assist R75 to deve of coping and interto express feelings.  R37's quarterly MD was severely, cogridiagnoses which in A progress note daindicated R75 was another resident (Finstructed R75 to see resident's personal agitated. R75 walksided upper body hand hit R75 in the hinjuries. R75 was aif she couldn't keep	n 12/07/16, at 2:22 p.m., RN)-B stated R49's coffee m by adding water. RN-B care plan indicated ice should up to keep it luke warm, not ght that intervention for R49  SIDENT ALTERCATION nimum Data Set (MDS) dated she was severely cognitively essed.  ted 09/29/16, indicated she epeatedly asking for certain mentia with behavior care plan directed staff to lop more appropriate methods acting, and to encourage R75 appropriately.	F 323			

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245438	B. WING	·····	12/	/08/2016
NAME OF PROVIDER OR SUPPLIER  TALAHI NURSING AND REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304		
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F 323	on 10/12/16, in the standing near R37 Staff offered R75 regive R37 some per some agitation tow was in Broda chair wheelchair) and R7 walker. She preceder a left sided hug make a fist with he Although staff offer the altercation with with interventions in after R37 struck R7 resident to resident residents safe.  LOOSE SIDE RAIL R3's quarterly Minit 8/11/16 identified F7 required extensive daily living (ADL's) morbid obesity and weakness.  During observation bed was fittend with a proximately 24" height. The rails we with a screw. Whe moved back and for bed frame.  During interview or registered nurse (F	dated 10/13/16, indicated that afternoon staff had noted R75, showing concern for her. eassurance and asked her to sonal space as R37 displayed ards others at this time. R37 (tilting and reclining 75 was ambulating using her ded to walk up to R37 and gave g. R37 then proceeded to r right hand and strike R75.  Ted reassurance to R75 before R37. There was no change mplemented for either resident, 75, to help reduce the risk of taltercations and keep both	F 323			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245438	B. WING	<del></del>	12/08/2016		
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	rails to assist her in When interviewed of stated the side rails and were difficult to loose.  During interview on registered nurse (R "wobbly" which place and may become a rails became any lo  On 12/08/16, at 1:0 facility practice was maintenance with of Further, MS stated for side rail mainter  Review of policy title identified staff mem rail is safe, provide utilized within manu 483.45(d) DRUG R UNNECESSARY D  (d) Unnecessary Dr drug regimen must drugs. An unneces used	d R3 frequently used the side sitting up in bed.  on 12/05/16, at 3:22 p.m. R3 had always been "very loose" use when they were that  12/05/16, at 6:53 p.m. the N)-A stated R3's side rails felt ted the resident at risk for falls in entrapment risk if the side oser.  3 p.m. MS stated the usual for facility staff to notify oncerns with paper slips. there was no system in place hance.  ed, "Side Rails" dated 6/11/16 beers are to assess the side education to residents and are affacture's instructions.  EGIMEN IS FREE FROM RUGS  rugs-General. Each resident's be free from unnecessary sary drug is any drug when see (including duplicate drug uration; or	F 325			1/17/17	
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	ETATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
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F 329		ate indications for its use; or	F 32	9		
	which indicate the discontinued; or  (6) Any combination paragraphs (d)(1) to This REQUIREMED by: Based on interview facility failed to ensinterventions and becompleted prior to medications for 1 of for unnecessary medications include:  R80's quarterly Mir 08/11/16, indicated impairment with a cand anxiety disorded R80's Care Area As 11/15/16, noted R8 psychosis and requone with activities of R80's care plan da had an identified pranti-anxiety medication anxiety disorder." In	nimum Data Set (MDS) dated R80 had no cognitive diagnosis of major depressive		F329 Drug Regimen is Free from Unnecessary Drugs  Talahi Nursing and Rehab Center ensure that residents are free from unnecessary dru7ggs without adecindications.  R80 care plan was updated to inclusigns and symptoms of anxiety and non-pharmacological approaches attempt prior to administration of lorazepam.  The psychotropic medications use guideline policy was reviewed and updated.  All residents who receive PRN psychotropic medications were revito ensure non-pharmaceutical interventions are in place and atterprior to medication administration.	quate quate ude d to	
	symptoms and doc	eument per facility protocol. eation of how R80's exhibited		Audit to ensure non-pharmaceutical interventions are trialed prior to medication administration up to five random residents per week for two	e	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED  12/08/2016	
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304	, .=.	33/2010
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F 329	During observation to 2:28 p.m. R80 e anxiety. During ob a.m. to 8:30 a.m., anxiety.  Review of R80's m (MAR) indicated R (medication used to (mg) tablet every of disorder. Further, to were to document non-pharmacologic effectiveness beformedication.  Review of the MAR In August 2016, R8 lorazepam on 2 differisodes did not in non-pharmacological In September 2016 lorazepam on 10 dabove episodes non-pharmacological attempted prior to In October 2016, Florazepam, and signon-pharmacological attempted prior to There was no indicated was being given.  In November 2016	n on 12/6/16 between 1:45 p.m. exhibited no outward signs of observation on 12/7/16 from 6:00 R80 presented no signs of medication administration record 80 had an order for lorazepam to treat anxiety) 0.25 milligrams in hours as needed for anxiety the order specified facility staff signs of anxiety, cal interventions used and its re administering the readministering the readministering the readministerions used.  6. R80 took her as needed different occasions of which both dentify any signs of anxiety or cal interventions used.  6. R80 took her as needed different occasions. During the osigns of anxiety, or cal interventions were the use of the medication.  880 received 7 doses of gns of anxiety, or cal interventions were the use of the medication.  880 received 7 doses of gns of anxiety, or cal interventions were the use of the medication.	F 329	months who receive PRN psycho medications.  All staff have been re-educated to non-pharmacological intervention administration of anti-anxiety med QAPI committee will review all au compliance at regularly scheduled meetings and make recommendation continuance.  DON/designee is responsible.	s prior to lications. dits for	
	lorazepam and sig	ns of anxiety, or				

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	245438		B. WING		12/08/2016		
	NAME OF PROVIDER OR SUPPLIER  TALAHI NURSING AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 329	medication.  Review of R80's phon 01/20/16, the coindicated facility stabehaviors, non-phaattempted and effectiveness of the is no rational for the current dose for R80 Review of an undat "Psychotropic Medicated facility at the content of the current c	armacist drug regimen review nsultant pharmacist (CP) off needed to document rmacological approaches of tiveness for R80's as needed 14/16, the CP again indicated on R80's lorazepam needed on R80's lorazepam needed and non-pharmacological standard non-pharmacological ehaviors prior to administering depam. Further, RN-D stated vior monitoring or all interventions attempted is medical record.  On 12/07/16, the director of edit was important for facility on-pharmacological ehaviors "to evaluate" the eas needed lorazepam. There is use of this medication at the one of the director of edit was important for facility on-pharmacological ehaviors "to evaluate" the eas needed lorazepam. There is use of this medication at the one of facility policy titled, cation Use Guidelines", xiety medication administered difacility staff to "bjectively" document	F 329				
F 353 SS=E	483.35(a)(1)-(4) SU	IFFICIENT 24-HR NURSING	F 353	3		1/17/17	

	ID DUANT OF CORDECTION TO THE TOTAL NUMBERS		MULTIPLE CONSTRUCTION UILDING		(X3) DATE SURVEY COMPLETED	
		245438	B. WING _		12	/08/2016
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F 353	Continued From part 483.35 Nursing Ser The facility must hat the appropriate comprovide nursing and resident safety and practicable physical well-being of each resident assessment and considering the diagnoses of the fart §483.70(e). [As linked to Facility be implemented be (Phase 2)]  (a) Sufficient Staff. (a)(1) The facility must sufficient numbers of personnel on a 2 nursing care to all resident care plans.  (i) Except when wait this section, license.	ge 45 vices ve sufficient nursing staff with opetencies and skills sets to defend related services to assure attain or maintain the highest lesident, as determined by onts and individual plans of care enumber, acuity and cility's resident population in efacility assessment required of Assessment, §483.70(e), will ginning November 28, 2017  ust provide services by of each of the following types 4-hour basis to provide esidents in accordance with esidents; and ersonnel, including but not	F 35	DEFICIENCY)		
	this section, the fac nurse to serve as a duty.  (a)(3) The facility m	waived under paragraph (e) of ility must designate a licensed charge nurse on each tour of ust ensure that licensed ecific competencies and skill				

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F 353	identified through re described in the plate (a)(4) Providing car assessing, evaluati resident care plans needs. This REQUIREMENT by: Based on observative review, the facility finursing staff to meed of 5 residents (R4 reviewed for activiti residents (R94) reviewed for activiti residents (R94) reviewed for activiti residents of 10 staff members NA-D, LPN-C, SM-voiced concerns wistaff in the facility.  Findings include:  ASSESSED RESID MET:  See F282: The factorie was implement R49, R94 and R87) dependent on staff (ADLs).  See F312: The factorie for activities of staff for activities ac	are for residents' needs, as esident assessments, and an of care.  e includes but is not limited to ng, planning and implementing and responding to resident's  NT is not met as evidenced ion, interview and document alled to provide sufficient assessed resident needs for 1, R49, R94 and R87) es of daily living, 1 of 3 iewed for pressure ulcers, and (R3, R50, R80, R20) and 10 is (NA-A, NA-C, NA-B, TMA-A, A, SM-B, SM-B, RN-A) who is the lack of sufficient nursing illity failed to ensure the plan of ited for 4 of 5 residents (R41, reviewed who were for activities of daily living illity failed to provide baths and stance for 2 of 3 residents dithat were dependent upon	F 35	F353- Sufficient 24 hour Nursing Section Per Care Plans  Talahi Nursing and Rehab Center a sufficient staff to meet the needs or residents.  Community meetings were held wiresidents in regards to their needs.  Meetings were held with staff to dethe most appropriate allocation of like Review of call light response times determine trends or patterns.  Call light policy and procedure reviand is current.  Information in regards to staffing procedures was communicated at Resident Council.  Staffing information was shared at meeting.  Staff re-educated to call light policy procedure.	assures f its th the . etermine hours. to to ewed	

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F 353	reduce the risk of p. 1 of 3 residents (RS pressure ulcers.  RESIDENT CONC STAFFING:  R3's quarterly Mining 8/23/16, identified is required extensive.  During interview on stated the facility late meet her needs timestaff were getting, they had to rush the enough staff. R3 surine that same dawith toileting quickly feel, "Upset and full R3's Device Activity 12/8/16, identified to times:  On 11/25/16, at 1 for 22 minutes and On 11/27/16, at 1 for 43 minutes and On 11/28/16, at 7 for 16 minutes and On 11/30/16, at 1 for 15 minutes and On 11/30/16, at 6 for 21 minutes and	ting and repositioning to pressure ulcer development for 194) identified at risk of the triple of trip	F 35	Education provided to direct regarding best practice for to bathing.  Audits of staff and resident in be conducted weekly in rega and meeting resident's need QAPI committee will review a compliance at regularly schemeetings and make recomm continuance.  DON/designee, Human Reserves ponsible.	nterviews will ards to staffing s. all audits for eduled nendations for	

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F 353	59 minutes and 20 - On 12/2/16, at 12 was on for 47 minu R50's quarterly MD R50 had intact cog		F 350	3		
	During interview on stated the facility no resident care. R50 the bathroom and, close" to having inc	12/5/16, at 2:10 p.m. R50 eeded more staff to completed stated he needs help to use at times, has come, "Pretty continence because there is assist him promptly.				
	12/8/16, identified t times: - On 11/30/16, at 25 for 23 minutes and - On 11/30/16, at 15 for 19 minutes and - On 12/7/16, at 3:0 16 minutes and 32	1:42 a.m. the call light was on 28 seconds; 3 a.m. the call light was on for seconds and; 3 a.m. the call light was on for				
		dated 11/15/16, identified R80 and required extensive Ls.				
	stated the facility w R80 stated she had assistance before a	12/5/16, at 2:30 p.m. R80 as not adequately staffed. It waited up to 30 minutes for and at times just has to, "Hang so she doesn't have				

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F 353	Continued From pa		F 3	53			
	12/8/16, identified the times: On 11/30/16, at 6: for 22 minutes and On 12/7/16, at 7:1 18 minutes and 41 On 12/7/16, at 11: for 16 minutes and 11: for 16 minutes and 12/6/16, identified Fimpairment.  During interview on stated the facility diprovide timely assistated he often has help, even after alrefurther, R20 stated before and it took s responded to help for sistential took s responded to help for sistential took s responded to help for sistential took s residents become used to make the facility of the formal transfer of the formal transfe	0 a.m. the call light was on for seconds and; 36 a.m. the call light was on 54 seconds.  imum Data Set (MDS) dated R20 had moderate cognitive  12/5/16, at 6:11 p.m. R20 d not have enough staff to stance with his needs. R20 to wait up to 15 minutes for eady asking for assistance. I he had fallen in the hallway everal minutes before staff nim.  S WITH LACK OF STAFFING:  12/6/16, at 2:06 p.m. nursing ated the facility is typically uple times a week," and upset their cares are not ely manner adding, "They se it." NA-A stated the not always completed if they ad staff run around the facility, their heads cut off," trying to					

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F 353	stated the nursing days and being fur main unit of the far happening anymore get four aides." No complete all of the like bathing, becan NA-C stated the rowhen their baths as Further, NA-C stated the concerns with nurse managers as however, staff are During interview of stated the memory care three NA staff tho because administ "Standing around NA staff was not eadequately or safe aides because of stated resident cathe lack of sufficient [resident] not getting further, NA-B stated the lack of staff hamanagers and ad When interviewed trained medication typically would on what we need," ar result. TMA-A stastaffed, "At least the staffed,	on 12/6/16, at 2:28 p.m. NA-C staff was, "Really short," some II staffed with four aides on the cility was not consistently re adding, "We're lucky if we A-C stated it was difficult to assigned cares for residents, use of the lack of staffing. esidents, "Get really upset," and cares aren't completed. ted several staff had reported lack of sufficient staff to the and administration of the facility, just told, "We're working on it."  In 12/6/16, at 2:45 p.m. NA-B y care unit is typically staff with and a cart nurse. NA-B stated unit used to be staffed with ugh, however, it was changed ration felt people were just, down here." NA-B stated two enough to care for the residents ely, "You need to have three the behaviors we have." NA-B re was suffering as a result of int staffing adding, "They're ing bathed," consistently. ted these concerns regarding ad been, "Voiced strongly," to	F3	\$ 5			

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F 353	cares not being cor  During interview on stated the memory staffed with three N NA-D stated if they the day, then cares good." Further, NA motion and bathing they were short state can get it, sometim  When interviewed clicensed practical in residents had voice sufficient staffing in residents had particibaths not being cor stated she had repestaff to the adminis  During interview on human resources of in charge of making the facility. The fact communicate with slevels for each day staffing for the facil nurses or TMA staff there was less NA sweren't scheduled in was provided by HI determining staff lesidentified different good population numbers number of NA staff the staff to the staf	inpleted.  12/7/16, at 4:03 p.m. NA-D care unit was supposed to be IA staff and a cart nurse. did not have full staffing for suffer and were, "Not that a-D stated residents' range of was not always completed if ffed adding, "Sometimes you es you can't."  10 12/7/16, at 4:47 p.m. curse (LPN)-C stated several ed concerns about a lack of the facility. LPN-C stated cularly complained about their mpleted. Further, LPN-C orted concerns about a lack of tration.  12/8/16, at 9:52 a.m. the director (HRD) stated she was go the staffing assignments for staff" to determine the staffing. HRD stated the typical ity was nine NA staff with three f; however on the weekends staff scheduled because baths	F3	53			

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	PROVIDER OR SUPPLIER  NURSING AND REHA	B CENTER		STREET ADDRESS, CITY, STATE, ZIP C 1717 UNIVERSITY DRIVE SOUTHEA SAINT CLOUD, MN 56304	ODE	00/2010
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F 353	identified the follow facility census of 70  - NA for AM shift: 8  - NA for PM shift: 6  - NA for night shift: 6  - NA for night shift: 6  - NA for night shift: 6  - Nurse/TMA for AM  - Nurse/TMA for night shift: 6  - Nurse/TMA for night shift: 7  - Nurse/TMA for night shift: 9  - Nurs	ring desired staffing levels for a control (as it was during the survey):  3.6 - 8.9 (staff) 3.9 - 7.1  2.8 - 2.9  A shift: 3.5 - 3.6  A shift: 3.5 - 3.6  The shift: 2.0  The stated the facility was short be staff in the example of a complaints were heard, "A complaints were he	F 35	53		

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F 353	unit to complete b SM-C stated complete stated several resident cares were sustated several resident processed in the recent months "You just get frustrous just get frustrous get frustrous when interviewed registered nurse (several resident castaffing, including evening prior when minutes for assistated was, "An extended Further, RN-A state concerns with a late forwarded to the sof nursing (DON).  On 12/8/16, at 2:1 administrator were the facility. The fate to determine staffing and acuity was also the staffing in the because the care been observed to levels, "I know its typically speaks werounds and was an had been brought staffing, however, enough of a concestaffing levels in the administrator state moving to a primal	aths and help on the floor.  bleting all assigned resident difficult with that staffing ratio," uffering as a result. SM-C ident and family concerns had cares not being completed in which was upsetting adding,	F3	53		

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F 365 SS=D	dated 12/2010, ider adequate staffing for directed staff to use assign scheduled in and attempt to replay 483.60(d)(3) FOOD INDIVIDUAL NEED (3) Food prepared individual needs; This REQUIREMENT by:  Based on observative review, the facility for easy consumption who had difficult cher in the facility for easy consumption who had difficult cher in the facility for easy consumption of the facility for easy consumption in the facility for easy consumption in the facility for easy consumption of the facility for easy consumption in the facility for easy consumption	epartment Staffing policy ntified an objective, "To provide or the nursing floor," and e daily check in sheets to ursing staff to work groups, ace a call in if one occurs. IN FORM TO MEET IS on a form designed to meet INT is not met as evidenced alled to comprehensively an appropriately textured diet on for 1 of 1 residents (R57) ewing a regular diet.	F 36		n n a re on
	careful" with eating  During observation	of the evening meal service		Three audits per week for three weeks be conducted during meal times to ider	

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F 365	next to the dining roserved a hamburge only eaten approximand left the other has stated she couldn't too hard to chew, "I motioned with her has too hard to chew, "I motioned with her has about, "Dental probout a month prior.  R57's Regulatory Videntified R57 had habout, "Dental probout a month prior.  R57's Patient Progrompleted by the dehave, "Several teetl adding R57, "States chewing as she is reteth." Further, the bottom which was completed for R57. identified plan to addifficulty chewing her foods assessment. However the several teeth fract chewing." The asseplan to address R5 chewing her food, or service and the several teeth fract chewing. The asseplan to address R5 chewing her food, or service and the several teeth fract chewing her food, or service and the several teeth fract chewing her food, or service and the service and th	p.m. R57 was standing up from table. R57 had been and bun, however R57 had nately 1/2 of the hamburger alf uneaten on the plate. R57 keep eating it because it was because of the teeth," as she hand to her mouth.  Isist note dated 11/11/16, been anxious and fixated lems" with teeth having fallen ress Note dated 10/4/16, was entist and identified R57 to a fractured off at the gumline," as she is having trouble missing so many posterior note had a handwriting at the dated 10/27/16, and identified ant extensive dental work. The note lacked any dress R57's complaints of	F3	65	residents whom may be having diff masticating.  In-services were conducted with nustaff to ensure they are identifying a endorsing issues like difficulty chewmanagement.  QAPI committee will review audits compliance at regularly scheduled meetings and make recommendatic continuance.  DON/designee, Dietary Manger, Diresponsible	ursing and ving to for ons for	

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F 365	During interview on assistant (NA)-A stadiet at meals and he "Anywhere from 25 lately adding she had her food." Further, R57 had made any trouble chewing her when interviewed a speech language pospeech had not work months." SLP-A stawas having any trouadding, "This is the stated the repeated should have been for be addressed as Recould potentially just trouble chewing, "Texpected nursing to When interviewed a registered nurse (R R57's weight and in concern with difficut that had to be addressed no assessme complaints of troub	12/6/16, at 2:23 p.m. nursing ated R57 received a regular ad only been eating, to 75 percent" of her meals ad, "Never seen her finish all NA-A stated she was unaware complaints about having r food.  on 12/6/16, at 3:29 p.m. athologist (SLP)-A stated rked with R57, "In the last few ated she was unaware R57 ubles chewing her food first I've heard of it." SLP-A concerns of trouble chewing orwarded to her so they could 57 was at a nutritional risk and at stop eating I would have	F 365			
F 371 SS=F	STORE/PREPARE	on was provided.	F 371			1/17/17

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F 371	authorities.  (i) This may include from local produce and local laws or re  (ii) This provision of facilities from using gardens, subject to safe growing and form consuming for consuming form consuming form consuming form consuming form consuming for consuming form consuming	e food items obtained directly rs, subject to applicable State egulations.  oes not prohibit or prevent produce grown in facility compliance with applicable bod-handling practices.  does not preclude residents ods not procured by the facility.  are, distribute and serve food in ofessional standards for food  regarding use and storage of sidents by family and other afe and sanitary storage,	F3	F371-Food Procedure Talahi Nursing and Reh store food in accordanc standards for food serv During survey all out da discarded. The identified nonstick discarded during the su All opened unlabeled un ensure and jevity were	ab Center does e with professional ice safety.  ted food was frying pans were rvey.  ndated cans of	

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	PROVIDER OR SUPPLIER			1717 UNIVE	DRESS, CITY, STATE, ZIP CODE ERSITY DRIVE SOUTHEAST OUD, MN 56304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(E/	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD ISS-REFERENCED TO THE APPROPI DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 371	12/5/16, at 11:58 a. (DD). The following facility walk in cooled - 31-ounce contained 11/3/16 - Two-quart contained dated 11/21/16 - Two hot dogs in a grown quart contained dated 11/22/16 - Two-quart contained dated 11/22/16 - Two-quart contained approximately 1 1/2 - Two-gallon contained approximately 1 1/2 - Two-gallon contained 11/24/16 - Two-gallon contained 11/24/16 - Three-gallon contained 11/25/16 - Two-gallon contained 11/25/16 - Two-gallon contained 11/25/16 - Three-gallon contained 11/25/16 - Three-ga	y kitchen was completed on m. with the dietary director items were noted in the er:  er, of cherry topping dated er, 1/2 full, of cream style corn gallon bag dated 11/21/16 er 1/8 full of of mixed fruit er, 3/4 full, of fruit cocktail er of peaches, containing cups, dated 11/24/16 er, full of sweet potatoes her of bread stuffing dated ainer of turkey stock dated  on 12/5/16 at 12:03 p.m., the b) stated the dietary supervisor onsible to check for outdated basis. The DD stated that food up to seven days after initial	F3	Staff hacontair unused immed Daily a ensure The Diaudits to ensure kitcher Medica a week there a ensure Results discuss	ave been re-educated open ners are not allowed to be sted portions must be discarded liately.  Audits are conducted by the care no outdated food is in the key are there is no outdated food in the care no opened unused canson or jevity.  The stion rooms are audited three are no opened unused canson or jevity.  The stion rooms are audited three are no opened unused canson or jevity.  The stion rooms are audited three are no opened unused canson or jevity.  The stion rooms are audited three are no opened unused canson or jevity.  The stion rooms are audited three are no opened unused canson or jevity.  The stion rooms are audited three are no opened unused canson or jevity.	cooks to itchen. ee onths d in the e times ensure of	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION  NG		E SURVEY MPLETED
		245438	B. WING		12	/08/2016
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP 1717 UNIVERSITY DRIVE SOUTHE SAINT CLOUD, MN 56304	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  YMUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 371	DD stated the non-cook up small quar normally dispose the hesitant to do so refore of equipment.  During a subseque p.m., the DD stated sweet potatoes were going to use the gravy stock for future stated both items which items items in the facility. Items in the facility leftover food items ite	on 12/5/16 at 12:03 p.m. the stick fry pans were used to nitities of food. She would be scuffed pans, but was lated to a delay in replacement on tinterview on 12/7/16, at 1:08 if the left-over turkey stock and re from Thanksgiving. They hese items to make soup or re resident meals. The DD would make approximately servings of soup for the lity.  Ton 12/8/16 at 3:30 p.m.  (RD) stated leftover food items here days or less because of k of food-borne illness."  RD identified they had to use in three days or less, the items lity walk in cooler were there being opened.  Idated, titled "Food Storage," ed "Leftover food is used carded."	F3	71		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION  G		E SURVEY IPLETED
		245438	B. WING		12/	08/2016
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETION DATE
F 371	opened unlabeled/triples opened unlabeled/triples opened unlabeled/triples opened unlabeled/triples opened unlabeled/triples opened to predict of the supplements had because opened to predict of the supplements opened opened.  A policy for expiration opened.  A policy for expiration opened.  A policy for expiration opened.	on storage room an one undated can of Ensure for on 12/05/16, at 6:57 p.m.  N)-A examined the opened ity in the North and West ators and stated Ensure/Jevity 4 hours after it is opened. She wing" how long the een in the refrigerator and all open supplements sidents initials and date they event them from being used in date.  12/06/16, at 8:49 a.m. the stated all supplements should hen opened as they expired	F 37			1/17/17
	least once every 30	nysician Visits nust be seen by a physician at days for the first 90 days after east once every 60 thereafter.				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		245438	B. WING		12/0	8/2016
	PROVIDER OR SUPPLIER  NURSING AND REHA	B CENTER	-	STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 387	occurs not later that visit was required. This REQUIREMEI by: Based on interview facility failed to ensprovided at least or 90 days after admis who were newly ad Findings include: R31's admission m8/26/16, indicated r R31's hospital disclindicated she had be following a hospital diagnosis list, dated admission diagnosis along with a history (kidney damage), hobstructive pulmon A review of physicia notes identified the - On 8/31/16, R31 rassessed by her fronte indicated that to her "Advanced mwith multiple medic long-term placemeneed to transfer care On 10/17/16, 47 covisit, R31 had an approximate indicated and approximate care.	is considered timely if it in 10 days after the date the NT is not met as evidenced and document review, the ure that physician visits were not every 30 days for the first ssion for 1 of 5 residents (R31) mitted to the facility.  Inimum data set (MDS), dated no cognitive impairment.  In arge report, dated 8/19/16, peen admitted to the facility I stay related to leg pain. R31's d 12/7/16, identified an est of cellulitis (skin infection) of diabetes with nephropathy leart failure, and chronic ary disease.  In and physician assistant (PA) following:  The R31 needed monthly visits due nultiple co-morbid conditions ations" and that "Given in the skilled nursing facility will	F 387	F387- Frequency/Timelines of Phy Visits  Talahi Nursing Rehab Center assur residents are seen in a timely man accordance with rules and regulation R31 has been seen by a physician followed by the physician on a regulation basis.  Talahi Nursing and Rehab Center has contracted with new Medical Direct begin 1/1/2017 who is committed to seeing our residents in a timely man accordance with a compliance of all new admissions, it is maintained daily by the Health Unit Coordinator and review weekly by the DON.  QAPI committee will review audits to compliance at regularly scheduled meetings and make recommendatic continuance.  DON/designee, Social Service, Admissions, HUC are responsible.	res ner in ons. and is lar as or to o nner. track v y the red	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION		E SURVEY IPLETED
		245438	B. WING		12/	08/2016
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROFICIENCY)	D BE	(X5) COMPLETION DATE
F 387	completed, but the accept her as a pat occur within 30 day 8/31/16 initial physis. During interview on registered nurse (R difficult to find R31 primary physician with RN-A stated the sitt primary physician with when admitted to the facility policy. R continuity in physici contact if there wer. During interview on stated she felt "Abaexperience and "Didown" referring to result to the facility physician for status in the facility However, the DON care for that long.  During interview on director (MD)-A stated a consister nursing home. It was R31's primary physher until she had be physician, but indicated.	ment, an assessment was physician later declined to ient. The physician visit did not s, but 47 days since her cian visit.  12/7/16, at 12:27 p.m.  1N)-A stated it had been a new physician, when her vouldn't follow her anymore. Lation was rare that the vould stop seeing a patient he facility, and was unaware of N-A stated (R31) needed ans so staff knew who to be medical problems.  12/7/16, at 3:50 p.m. R31 andoned and frustrated" by the dn't like the way things went not being followed by a	F 387			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION  IG		E SURVEY PLETED
		245438	B. WING _		12/0	08/2016
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 387	States Bill of Rights facility would seek a "Assure provision o care and treatment	c Combined Federal and s, dated 11/28/16, directed the alternate physician services to f appropriate and adequate	F 38			44747
F 425 SS=D	(a) Procedures. A spharmaceutical ser that assure the acc dispensing, and adbiologicals) to meet (b) Service Consult employ or obtain the pharmacist who  (1) Provides consult provision of pharmatisms REQUIREMENT by:  Based on observative review, the facility fivere given according instructions for 1 of Findings include:  MANUFACTURE CR94's Individual Reference and aspiration and mouth (NPO). R94	facility must provide vices (including procedures urate acquiring, receiving, ministering of all drugs and the needs of each resident.  ation. The facility must e services of a licensed tation on all aspects of the acy services in the facility; NT is not met as evidenced ion, interview, and document ailed to ensure medications ag to manufactures 1 residents (R94).	F 42	F425- Pharmaceutical Services  Talahi Nursing Rehab Center does provide pharmaceutical services to the needs of each resident.  All opened and undated TB PPD v were discarded during survey.  The PPD was all relocated to one refrigerator at the north med room.  Audits are conducted weekly by the DON/designee to assure all opened PPD is dated.	o meet ials .	1/17/17

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	` /	SURVEY PLETED
		245438	B. WING			12/0	08/2016
	PROVIDER OR SUPPLIER	B CENTER		17	TREET ADDRESS, CITY, STATE, ZIP CODE 717 UNIVERSITY DRIVE SOUTHEAST AINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 425	R94's Dismissal Sudated 12/1/16, indic (difficulty swallowing (percutaneous endoplaced in abdomina nutrition, fluids and into the stomach, be esophagus) tube preceive myrbetriq (roveractive bladder) release (designed tover a extended permorning.  A speech therapy (\$12/02/16, indicated on command and hoted.  During observation listened practical numedications. LPN-medications except stated the medication and could not be crigiven by mouth. LF administered R94's myrbetriq, via peg twould not be able to she was uncertain in the process of the process of the medication of the process of the process of the medication of the process of the medication of the process of the proces	mmary from Mayo Clinic cated R94 had dysphagia g) and had a peg oscopic gastrostomy, which is all wall and stomach to allow for medications to put directly ypassing the mouth and laced. Further, R94 was to medication for treatment of 25 milligrams (mg) sustained or release medication in body riod of time) by mouth every set. Plan Of Care, dated R94 was unable to swallow and no spontaneous swallow and no spontaneous swallow.  12/07/16, at 10:40 a.m. urse (LPN)- D set up R94's for THE myrbetriq. LPN-D on was "sustained released" ushed, and was ordered to be PN-D entered R94's room and medications, except ube. LPN-A then stated she or give R94 myrbetriq because f R94 could swallow the pill.  //07/16, at 1:00 p.m. LPN-D in the R94's physician who striq. LPN-D also stated R94 yrbetriq five times since uncertain how the staff	F 4	25	R94 mybetriq was discontinued.  DON/designee is responsible to receach MAR on admission to assure method of administration is noted.  QAPI committee will review audits compliance at regularly scheduled meetings and make recommendatic continuance.  DON/designee is responsible.	proper	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	PLE CONSTRUCTION  G		E SURVEY IPLETED
		245438	B. WING		12/	08/2016
	ROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETION DATE
F 431 SS=E	have been giving the and administering it stated the nurses stated	DON) stated the staff must e myrbetriq by crushing it, ivia the peg tube. The DON hould have clarified this order in.  Int interview on 12/08/16, at lated she had given R94 ing it and giving it via R94's requested on giving ing to manufacture was not received.  In from the manufacture of the tablet whole. Do not crush in DRUG RECORDS, UGS & BIOLOGICALS ovide routine and emergency is to its residents, or obtain the ement described in art. The facility may permit el to administer drugs if State y under the general ensed nurse.	F 42			1/17/17
	(2) 3311130 33113411	and the radiity made				

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		245438	B. WING		12/0	8/2016
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 431	pharmacist who  (2) Establishes a sydisposition of all codetail to enable an  (3) Determines that that an account of a maintained and performance and biological labeled in accordar professional principal appropriate access instructions, and that applicable.  (h) Storage of Drug (1) In accordance with facility must stolocked compartment controls, and perminave access to the  (2) The facility must permanently affixed controlled drugs liss Comprehensive Drug Control Act of 1976 abuse, except whe package drug distriquantity stored is more readily detected This REQUIREMED	ystem of records of receipt and ontrolled drugs in sufficient accurate reconciliation; and all controlled drugs is riodically reconciled.  gs and Biologicals. als used in the facility must be nee with currently accepted oles, and include the cory and cautionary are expiration date when the surface with State and Federal laws, ore all drugs and biologicals in this under proper temperature it only authorized personnel to keys.  It provide separately locked, docompartments for storage of ted in Schedule II of the rug Abuse Prevention and and other drugs subject to the facility uses single unit ibution systems in which the ninimal and a missing dose can l.  NT is not met as evidenced	F 43			
		tion, interview, and document failed to ensure insulin and		F431- Drug Records, Label/Store		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE S COMPL	
		245438	B. WING		12/08	B/2016
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304		
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F 431	tuberculin solution and expired Novol Lantus insulin (mervials were removed not administered to who used insulin we failed to ensure tub for resident and state This had potential R98 and R95) who Findings include:  INSULIN  R2's quarterly Mini 10/28/16, identified mellitus (metabolic blood glucose leve Review of R2's undidentified R2 receiv diabetes) 90 units morning and 56 undigentified R2/16, identified mellitus (metabolic blood glucose leve R31's quarterly Minimum 10/22/16, identified mellitus (metabolic blood glucose leve R31's quarterly Minimum 11/19/16, identified mellitus (metabolic blood glucose leve Review of R31's uridentified R31 recediabetes) 5 units states.	bottles were dated when open, in, Novolog, Levemir, and dication used to treat diabetes) of from medication carts and of 2 of 11 residents (R2, R31) within the facility. Further, facility perculin solution was available aff use and were not expired. To affect 3 of 9 residents (R93, received the expired solution.  The mum Data Set (MDS) dated the expired solution.  The mum Data Set (MDS) dated the expired solution.  The mum Data Set (MDS) dated the expired solution.  The mum Data Set (MDS) dated the evening. R69's the evening the evening the evening. R69 had type two diabetes disease causing increase the and may require insulin).  The mum Data Set (MDS) dated the evening increase the sand may require insulin).  The mum Data Set (MDS) dated the evening increase the	F 431	Talahi Nursing and Rehab Center of provide pharmaceutical service to rathe needs of each resident.  R2 and R31 insulin were discarded time of the survey.  All insulin is dated when opened.  Staff have been re-educated to the procedure of opening and dating in Med carts will be audited two times week for three weeks to ensure all that is opened is dated.  All opened and undated TB PPD viwere discarded during survey.  The PPD was all relocated to one refrigerator at the north med room.  Audits are conducted weekly the DON/designee to assure all opened PPD is dated.  R94 Mybetiq was discontinued.  DON/designee is responsible to releach MAR on admission to assure method of administration in noted.  QAPI will review audits for complia regularly scheduled meetings and recommendations for continuance.  DON/designee is responsible.	sulin. als d TB view proper nce at make	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION  NG		E SURVEY IPLETED
		245438	B. WING _		12/	08/2016
	PROVIDER OR SUPPLIER  NURSING AND REHA	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 431	12/06/16, at 11:57 a delivery date from and R31's Levemir 10/22/16.  When interviewed on ursing assistant (Nobserve an expiration insulin. Further, NA insulin's for these recart which she (NADuring interview 12 nurse (RN)-A stated opened it should be date as it was only been opened.  A review of a the melli Lilly instructs to expired 30 days after review of manufact Nordisk stated Leved days after it is opened.  TUBERCULIN:  On 12/05/16, at 05: storage room was of (RN)-D. The West is contained an opened Purified Protein Delused to test for expexpiration date of 1 RN-D stated the tulf for residents and fastated expired TB services.	of the medication cart a.m. R2's Humulin insulin had a the pharmacy on 10/25/16 insulin had a delivery date of an 12/05/16, at 12:25 p.m. IA)-L stated she did not on date on R2's, R31's -L stated there were no other esidents on the medication IL) was aware of. IS/16, 6:43 p.m. registered d once a resident's insulin was a labeled with an expiration good for 30 days after it has anufacturers instructions from discard Humulin insulin er it is opened. Further, a urers instructions from Norvo emir insulin is expired after 42	F 4:	31		

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION		E SURVEY PLETED
		245438	B. WING		12/	08/2016
	PROVIDER OR SUPPLIER	B CENTER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPOLICIENCY)	BE	(X5) COMPLETION DATE
F 431	TB Screening for no residents" R94 was number 772984) or expired. R93 was gnumber 772984) or expired and R98 wanumber 772984) or expired.  During observation the Rosewood med assistant director or inside the medication package of Tubercowith date of when the stated the tuberculin resident use, but watuberculin solution, solution should have days from being op knowing when the swas not dated.  A facility policy on expired.  A facility policy titled and Storage" dated is to be dated on the	cumentation titled, "Baseline ursing home and boarding given an expired TB test (lot in 12/1/16, 21 days after it iven expired TB solution (lot in 11/22/16, 12 days after it it is as administered TB test (lot in 11/21/16, 11 days after it in 11/2	F 431			
F 441 SS=F		e)(f) INFECTION CONTROL,	F 441			1/17/17

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION  IG		TE SURVEY MPLETED
		245438	B. WING _		12	/08/2016
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 1717 UNIVERSITY DRIVE SOUTHEAS SAINT CLOUD, MN 56304	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 441	The facility must es and control program a minimum, the follows of the followed to present a minimum, the following the followin	tablish an infection prevention (IPCP) that must include, at owing elements: eventing, identifying, reporting, ontrolling infections and ases for all residents, staff, and other individuals under a contractual upon the facility assessment of the second o	F 44			

	AN OF CORRECTION IN INFRIED IN INFRIED.		PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		245438	B. WING _		12/08/2016	
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304	12/00/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLÉTION	
F 441	least restrictive post circumstances.  (v) The circumstant must prohibit employed disease or infected contact with reside contact will transmit (vi) The hand hygie by staff involved in (4) A system for required the facility's actions taken by the (e) Linens. Person process, and transpersed of infection.  (f) Annual review of its program, as necess This REQUIREMED by:  Based on interview facility failed to imprintection control protracking, trending a infections to prever This had potential to	hat the isolation should be the sible for the resident under the sible for the resident under the ces under which the facility byees with a communicable skin lesions from direct at the disease; and the procedures to be followed direct resident contact.  Cording incidents identified PCP and the corrective efacility.  The facility will conduct an alpCP and update their sary.  Note that a comprehensive by and document review, the lement a comprehensive by and document review, the lement a comprehensive by and analysis of illnesses and an analysis of illnesses and an analysis of residents, staff	F 44	F441- Infection Control  Talahi Nursing and Rehab Center maintains an infection prevention program.		
	failed to ensure sta change with approp	acility. In addition, the facility ff completed a dressing oriate hand hygiene for 1 of 1 served during wound cares.		Infection control policies and prochave been updated, and are curred Infection control tracking forms for residents and employees has been created to include all pertinent day regarding the infection.	ent. or en	

STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION	S	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245438	B. WING			12/0	08/2016	
NAME OF PROVIDER OR SU  TALAHI NURSING AND		B CENTER		17	TREET ADDRESS, CITY, STATE, ZIP CODE 717 UNIVERSITY DRIVE SOUTHEAST AINT CLOUD, MN 56304		7,2010	
PREFIX (EACH DEF	ICIENC,	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
(DON) on 12 representing control monit identified:  SEPTEMBEI  An Order Lis four different during the mincluded a urinfection, pnel lacked any droom number determined tracquired.  A single Empidentified an of, "Puking, so In addition, so Services repidentified diff specimens. residents had same bacter on the date of infection was in-house acquired.  The collected analysis of the determine the	ting Records and the records are shown at the control of the contr	ded by the director of nursing with different tabbed sections specific month of infection The following information was	F 4	41	Infection control committee meets to analyze any trending in the data collected for infections.  QAPI meets monthly and reviews information collected by the infection control committee.  The clean dressing change policy been reviewed and is current. Nurshave been re-educated on the clear dressing change technique.  Random audits will be conducted to whom complete dressing changes ensure proper technique is followed.  QAPI committee will review audits compliance at regularly scheduled meetings and make recommendatic continuance.  DON/designee is responsible.	on nas ses in on staff to d.		

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>*</sup> A. BUILDI	TIPLE CONSTRUCTION			E SURVEY PLETED
		245438	B. WING			12/0	08/2016
	PROVIDER OR SUPPLIER  NURSING AND REHA	B CENTER		STREET ADDRESS, CITY, STATE, 1717 UNIVERSITY DRIVE SOU SAINT CLOUD, MN 56304			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O  X (EACH CORRECTIVE AC  CROSS-REFERENCED TO  DEFICIEN	CTION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE
F 441	six residents had remonth for different chronic pain syndrosevere sepsis. The symptom onset or room numbers, or it to be community or An undated Infection resident had an infection of infection has spacing to place a symptoms. However, blank and no data was type of infection the symptoms which has additional Infect different resident was admission; however information. The reblank and no data was type of infection the symptoms which has type of infection the symptoms which has type of infection the symptoms which has the collected data analysis of the infection the cause had potential to, or NOVEMBER 2016:  An Order Listing Research	eport dated 12/5/16, identified eceived antibiotics during the diagnosis which included ome, pneumonia, yeast, and export lacked any dates of resolve, organism cultures, if the infection was determined in-house acquired.  In Report Form identified a rection noted to begin on the diagnosism to identify what doccurred including additional checkmark in corresponding er, all of these fields were left was entered to identify what excident had or any addeveloped.  In Report Form identified a resident had or any addeveloped.  In Report Form identified a resident had or any addeveloped.  In Report Form identified a resident had or any addeveloped.  In Report Form identified a resident had or any addeveloped.  In Report Form identified a resident had or any addeveloped.  In Report Form identified a resident had or any addeveloped.  In Report Form identified a resident had or any addeveloped.  In Report Form identified a resident had or any addeveloped.	F 4	41			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION  NG		TE SURVEY MPLETED
		245438	B. WING _		12	/08/2016
	PROVIDER OR SUPPLIER  NURSING AND REHA	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 1717 UNIVERSITY DRIVE SOUTHEAS SAINT CLOUD, MN 56304	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 441	urinary tract infection a, "Rash." The rep symptom onset or rorganism cultures, determined to be considered.  The data lacked an infections in the face each infection or if spreading in the face each infection or infection or infections during throughout the week processes for tracket in the symptom of	diagnosis which included on, bronchitis, pneumonia, and ort lacked any dates of resolution, room numbers, or if the infection was ommunity or in-house by trending or analysis of the cility to determine the cause of they had potential to, or were cility.  The information provided for any of the program was no longer cility and they were in the cassigned to someone else to the DON stated the infection exed consistent monitoring, sof the collected data adding, to a better system," and, and of that [infections in the ne DON stated she had been	F 44			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245438	B. WING			12/	08/2016
	PROVIDER OR SUPPLIER	B CENTER		17	TREET ADDRESS, CITY, STATE, ZIP CODE 717 UNIVERSITY DRIVE SOUTHEAST AINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPORTION OF T	BE	(X5) COMPLETION DATE
F 441	2/16/16, identified a "Help prevent the dof disease and infeseveral elements or included, "Surveilla collection," and havinvestigation, and or infectious disease.' summaries of the irrand analyzed by the with findings being changes in practice. HAND HYGIENE R39's admission M7/12/16, identified Far a diagnosis of congright above the kne R39's significant change to left heel: saline, dry. Cover with Change daily and or During observation practical nurse (LPI gloves. With her classified bandage from in the trash. Without gloves, LPN-A-A or accidentally dropped the bandage off the her (LPN-A's) pock dressing without firs With her same soiled	control Program policy dated an objective which included, evelopment and transmission ction." The policy identified if the facility program which nee based on systemic data ring, "A system for detection, ontrol of outbreaks of "Further, the policy identified a infections were to be compiled a infection control committee, communicated to determine if a or procedures were required.  Inimum Data Set (MDS) dated a manual m	F	141			

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  IG		E SURVEY PLETED
		245438	B. WING _		12/	08/2016
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETION DATE
F 441	the soiled bed linenge she placed a new content han proceeded to we bathroom.  When interviewed content has proceeded to we bathroom.  When interviewed content has proceeded to we be laster she (LPN) dug in her pocket we stated R39's heel so bed after being irrig R39's risk for an infit is important to do when working with was a higher risk of and an increased rid During interview on assistant director of wearing dirty gloves and increased their pressure ulcer on how the pressure ulcer on how the pressure ulcer of the pres	placed his clean heel unto. With her same soiled gloves, lean dressing over R39's left ved her soiled gloves. LPN-A wash her hands in R39's  on 12/07/16, at 7:33 a.m.  urse (LPN)-A stated she ressure ulcer on R39's left -A) touched the ground and with her gloved hands. LPN-A hould have not touched the ated because it increased ection. Further, LPN-A stated n on a clean set of gloves pressure ulcers because there is "contaminating" the area sk of infection.  12/07/16, at 11:18 a.m. the increased in fursing (ADON)-A stated is could contaminate the area isk of infection to R39's is left heel.  on 12/07/16, at 11:43 a.m. the stated it was "inappropriate" es during pressure ulcer d increase the risk of infection er on R39's left heel.  and hygiene was requested, ring the survey.  SPONSIBILITIES OF	F 44			1/17/17
SS=D	MEDICAL DIRECTO  (h) Medical director	OR				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			X3) DATE SURVEY COMPLETED	
		245438	B. WING _		12/0	08/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304	, .=.	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 501	(2) The medical director to address continuity for 1 of 1 receive medical caphysician.  Findings include:  R31's admission m8/26/16, indicated she had be following a hospital also indicated as following a hospital also indicated a following a hospital also indicated an admission infection along with nephropathy (kidnechronic obstructive).  A review of physicin notes identified the On 8/31/16, R31 reassessed by her processed by her processed in the control of the c	st designate a physician to lirector.  rector is responsible for- of resident care policies; and on of medical care in the facility. NT is not met as evidenced of and document review, the laborate with the medical oconcerns of physician residents (R31) who did not are under a consistent of the facility all stay related to the facility all stay related to leg pain, which low up appointment with her at the facility in one week. It, dated 12/7/16, further at the facility in one week. It, dated 12/7/16, further at the facility in one week. It, dated 12/7/16, further at the facility in one week. It, dated 12/7/16, further at the facility in one week. It, dated 12/7/16, further at the facility in one week. It, dated 12/7/16, further at the facility in one week. It, dated 12/7/16, further at the facility in one week. It, dated 12/7/16, further at the facility in one week. It, dated 12/7/16, further at the facility in one week. It, dated 12/7/16, further at the facility in one week. It dated 12	F 50	F501- Responsibilities of the Me Director  Talahi Nursing and Rehab Centeresident are seen in a timely ma accordance with rules and regular followed by the physician on a rebasis.  Talahi Nursing and Rehab Centeresident are seen by physician on a rebasis.  Talahi Nursing and Rehab Centeresident our residents in a timely reseing our residents in a timely reseing our residents in a timely readmissions, it si maintained daily HUC and reviewed weekly by the QAPI committee will review audicompliance at regularly schedule meetings and make recommend continuance.  DON/designee, Social Services, Admissions, HUC are responsib	er assures nner in ations.  and is egular  er has irector to d to manner.  I to track new / by the e DON.  ts for ed lations for	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION		E SURVEY IPLETED
		245438	B. WING		12/	08/2016
	PROVIDER OR SUPPLIER  NURSING AND REHA	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPOLICIENCY)	D BE	(X5) COMPLETION DATE
F 501	conditions with muli "Given long-term p facility will need to on 10/17/16, 47 da R31 had an appoint different physician, assessed R31. The be contacting the faconcerning R31's recare." On 10/24/16 as a patient recomprovider, and offere facility.  On 11/3/16, 76 day an appointment wit R31, the PA-A also patient due to her correcommended an I On 11/18/16, 91 da R31 had an appoint facility who comple became her primare A facility Progress I the facility had requirector (MD)-A to because they were R31. A Progress I the facility Medical follow R31 as a patient of R31 in Septemb	dvanced multiple comorbid ltiple medications" and that lacement in skilled nursing transfer care."  ays after her last physician visit, atment to establish care with a MD-C outside the facility who e note identified MD-C would acility to "Clarify the issue non-eligibility for in-facility, MD-C declined to take R31 mending an Internal Medicine ed to place referral for the as a semplex medical history and internal Medicine Physician.  The safter she was admitted, atment with a MD-D outside the ted an assessment of R31 and the physician.  Note, dated 9/26/16, indicated uested the facility's Medical follow R31 starting 9/27/16, a unable to find a physician for lote, dated 10/26/16, indicated Director-A had declined to	F 50			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION  NG		E SURVEY IPLETED
		245438	B. WING	<del></del>	12/	08/2016
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP COL 1717 UNIVERSITY DRIVE SOUTHEAS SAINT CLOUD, MN 56304	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORR ( (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 501	Director-A had beer establish care with  During interview on stated she felt "Aba experience and "Didown" referring to reconsistent physicial seen by the Medica he couldn't follow he R31 stated since the wouldn't see her, she was "Just hoping at During interview on stated he wasn't abdue to her younger hadn't seen R31 in reviewed her chart referred to another unaware R31 had rephysician in Septencare twice. The MD facility to contact his stating he was ultimed buring interview on of nursing (DON) stinvolved in finding or refused to follow her the facility's Medicareviewed 1/29/16, include the "Overall in the facility to ens	indication the Medical nacontacted to assist R31 to a primary physician.  12/7/16, at 3:50 p.m. R31 and oned and frustrated" by the dri't like the way things went not being followed by a nace R31 stated she hadn't been all Director, but had been told er due to age and insurance. e facility's Medical Director ne "was hanging again" and not praying things got better."  12/7/16, at 5:29 p.m. MD-A le to take R31 as a patient age. He further stated he person in September, just and thought she was already physician. The MD-A was not been assessed by a naber or that she was denied and have expected the mach when R31 was denied care nately responsible for her care.  12/8/16, at 11:03 a.m. director atted MD-A should have been care for R31 since he had are as her primary physician.  all Director Agreement, dentified the responsibilities to a coordination of medical care ure the adequacy and the medical services provided	F 5	01		

	OF ISOLATED DEFICIENCIES WHICH CAUSE OF THE ONLY A POTENTIAL FOR MINIMAL HARM OF NFS	PROVIDER # 245438	MULTIPLE CONSTRUCTION  A. BUILDING:  B. WING	DATE SURVEY  COMPLETE:  12/8/2016		
	OVIDER OR SUPPLIER URSING AND REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN				
ID PREFIX FAG	SUMMARY STATEMENT OF DEFICIE	NCIES				
F 156	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18)  (d)(3) The facility must ensure that eac contacting the physician and other print §483.10(g) Information and Communi (1) The resident has the right to be information to conduct and responsibilities d (g)(4) The resident has the right to recin a format and a language he or she used (i) Required notices as specified in this description of legal rights which included (A) A description of the manner of process of the conduct of the requirements and informational agencies, resident and office, the State Long-Term Care Ombestervices where state law provides for joinformation about returning to the community of the community of the community of the community of the state of the State Survey Agency, the State Information and contact information to the State Survey Agency, the State Information and contact information to the State Survey Agency, the State Information and contact information to the State Survey Agency, the State Information and contact information to the State Survey Agency, the State Information and contact information to the State Survey Agency, the State Information and contact information to the State Survey Agency, the State Information and contact information to the State Survey Agency, the State Information and contact information to the State Survey Agency, the State Information and State of 1965, and advocacy system (as designated by the Assistance and Bill of Rights Act of 20 [§483.10(g)(4)(ii) will be implemented to the State Information regarding Medicare and Information re	ch resident remains mary care profession cation.  ormed of his or her stay eive notices orally (anderstands, including a section. The facility destands are tecting personal further and procedures for a crees under section and procedures for a crees under section and procedures for a crees under section and program, the unisdiction in long-termination and the Medical acomplaint with mursing facility regulation for State and local cong-Term Care On a samended 2016 (42 state, and as estable 2000 (42 U.S.C. 1500) and Medicaid eligibing Movembra and Medicaid eligibing markets.	rights and of all rules and regulations in the facility.  meaning spoken) and in writing (includes and particular and in writing (includes and resident a writing and an argument and argument and argument argument and argument argumen	governing  uding Braille)  ten  ction;  ncluding the  regulatory te licensure dult protective gency for  any esident abuse, the advance  ut not limited rection 712 on and		

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

The above isolated deficiencies pose no actual harm to the residents

Event ID: J6VE11 If continuation sheet 1 of 4

STATEMENT	OF ISOLATED DEFICIENCIES WHICH CAUSE ITH ONLY A POTENTIAL FOR MINIMAL HARM ID NFs	PROVIDER # 245438	MULTIPLE CONSTRUCTION  A. BUILDING:  B. WING	DATE SURVEY  COMPLETE:  12/8/2016				
NAME OF PROVIDER OR SUPPLIER  TALAHI NURSING AND REHAB CENTER		1717 UNIVERSI	STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN					
ID PREFIX FAG	SUMMARY STATEMENT OF DEFICIEN	CIENCIES						
F 156	Continued From Page 1  (iv) Contact information for the Aging (B)(iii) of the Older Americans Act); or [§483.10(g)(4)(iv) will be implemented (v) Contact information for the Medica [§483.10(g)(4)(v) will be implemented (vi) Information and contact information violation of state or federal nursing face exploitation, misappropriation of reside requirements and requests for information (g)(5) The facility must post, in a form representatives:  (i) A list of names, addresses (mailing and advocacy groups, such as the State Surstate law provides for jurisdiction in lo Ombudsman program, the protection and the Medicaid Fraud Control Unit; and the Medicaid Fraud Control Unit; and the Medicaid of state or federal nursing face exploitation, misappropriation of reside directives requirements (42 CFR part 4 community.	and Disability Resor other No Wrong Ed beginning Novem id Fraud Control U beginning Novembor for filing grievan ility regulations, incent property in the filing return and manner access and email), and televey Agency, the Stang-term care faciliting advocacy network and le a complaint with ility regulation, including property in the ferse subpart I) and resorted in the subpart II and	phone numbers of all pertinent State aguste licensure office, adult protective ser es, the Office of the State Long-Term ork, home and community based service the State Survey Agency concerning a uding but not limited to resident abuse actility.	ected e, neglect, ace directives esident gencies and evices where Care programs,  ny suspected e, neglect, dvanced ning to the				
	for admission, oral and written informa and how to receive refunds for previou	(g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.						
	(g)(16) The facility must provide a not during the resident's stay.	(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay.						
		(i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility.						
	(ii) The facility must also provide the robligations, if any.	esident with the Sta	te-developed notice of Medicaid rights	s and				

ENTERS 1	FOR MEDICARE & MEDICAID SERVICES			"A" FOF					
TATEMENT	OF ISOLATED DEFICIENCIES WHICH CAUSE	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY					
	ITH ONLY A POTENTIAL FOR MINIMAL HARM		A. BUILDING:	COMPLETE:					
OR SNFs AN	ID NFs	245438	B. WING	12/8/2016					
NAME OF PR	OVIDER OR SUPPLIER	STREET ADDRESS	, CITY, STATE, ZIP CODE	I					
TALAHI NURSING AND REHAB CENTER		1717 UNIVERS SAINT CLOUD	ITY DRIVE SOUTHEAST ), MN						
D PREFIX PAG	SUMMARY STATEMENT OF DEFICIE	ENCIES	CIES						
F 156	Continued From Page 2								
	(iii) Receipt of such information, and	any amendments to	it, must be acknowledged in writing;						
	(g)(17) The facility must								
	(i) Inform each Medicaid-eligible resident becomes eligible for		he time of admission to the nursing faci	lity and					
	(A) The items and services that are incresident may not be charged;	(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;							
	(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and								
	(ii) Inform each Medicaid-eligible resiparagraphs (g)(17)(i)(A) and (B) of the	eligible resident when changes are made to the items and services specified in ad (B) of this section.							
		the facility and of	at the time of admission, and periodical charges for those services, including an facility's per diem rate.						
			rices covered by Medicare and/or by the the change as soon as is reasonably pos						
	(ii) Where changes are made to charge inform the resident in writing at least (		nd services that the facility offers, the facility of	cility must					
	refund to the resident, resident represe	entative, or estate, as e days the resident a	nd does not return to the facility, the fact s applicable, any deposit or charges alro- ctually resided or reserved or retained a ce requirements.	eady paid,					
	(iv) The facility must refund to the res within 30 days from the resident's date		presentative any and all refunds due the the facility.	resident					
	not conflict with the requirements of the This REQUIREMENT is not met as each	hese regulations. evidenced by: ew, the facility fails	an individual seeking admission to the feed to provide the appropriate liability refrom Medicare services.	·					

STATEMENT C	OR MEDICARE & MEDICAID SERVICES OF ISOLATED DEFICIENCIES WHICH CAUSE OF ONLY A POTENTIAL FOR MINIMAL HARM OF NFS	PROVIDER # 245438	MULTIPLE CONSTRUCTION A. BUILDING: B. WING	DATE SURVEY  COMPLETE:  12/8/2016
NAME OF PROVIDER OR SUPPLIER  FALAHI NURSING AND REHAB CENTER			CITY, STATE, ZIP CODE ITY DRIVE SOUTHEAST , MN	1
D PREFIX CAG	SUMMARY STATEMENT OF DEFICIE	ENCIES		
F 156	Continued From Page 3 Findings include:  R64's admission Minimum Data Set (Matherapy while admitted in the facility.  R64's was provided and signed a Notice right to an immediate appeal through the R64's Medicare services were ending of received notice form CMS 10095, which form CMS 10123, and not the CMS 10095 and continued in the facility. R91 was a current R91's admission MDS, dated 11/18/16 resident in the facility. R91 was a current R91 received and signed liability notice on 11/24/16. Since R91 remained in the facility of the companies of the CMS 10123, and not the CMS 10123, and not the CMS 10123, and CMS 10123, and did not know when the delivering the liability notices to During interview on 12/8/16, at 2:56 prin forms CMS 10095 and CMS 10123.  Review of the CMS website identified had been replaced with the CMS 1012.  A copy of the facility's policy was required.	ce of Medicare Non- he QIO or Quality I on 11/7/16. R64 wa ch identified Straits 0095, which was the form CMS 10095 the facility, he also re obligations when Me 0095, which was the om. business office a stated she was unavano the facility's QIO residents. om. director of nursi , nor who the facility the CMS 10095 for 3.	Coverage CMS 10095 (which explain improvement Organization) on 11/4/16 is discharged from the facility on 11/8. Health as the QIO. R64 should have incorrect form.  Evived physical and occupation therapy acility.  on 11/22/16, regarding Medicare serveceived the a SNF determination on ordicare services end). R91 should have incorrect form.  Staff (BOS) stated the form CMS 100 ware of any difference between forms was. BOS stated she "never really lowed in the property of the p	ns a resident's 6, identifying /16. R64's received the  while a  vices ending continued stay e received the  95 was form CMS 10095 oked at them"

(X6) DATE

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SU IDENTIFICATION		(X2) MULTIPLE CONSTRUCTION (X3) DATI A. BUILDING:			SURVEY LETED
		00614		B. WING		12/0	) 8/2016
NAME OF I	PROVIDER OR SUPPLIER	00014	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	12/0	0/2010
TALAHI I	NURSING AND REHA	B CENTER		/ERSITY DR .OUD, MN 50	IVE SOUTHEAST 5304		
(X4) ID PREFIX TAG		TEMENT OF DEFICIE MUST BE PRECEDE SC IDENTIFYING INF	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Initial Comments			2 000			
	*****ATTE	NTION*****					
	NH LICENSING	CORRECTION	ORDER				
	In accordance with 144A.10, this correct pursuant to a surve found that the defic herein are not corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the Minnesota Department of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess that was violated ducorrected.	ction order has by. If, upon reins iency or deficiency or deficience assessed in a compliance with a rule provided a compliance with a rule provided a compliance will be Lack of compliancy items will be Lack of compliment of a fine euring the initial ir	ceen issued spection, it is notes cited each violation accordance ed by rule of th.  In has been all the tag sated below.  Is, failure to e considered ance upon part rule will ven if the item aspection was				
	that may result from orders provided tha the Department with notice of assessme	n non-compliand t a written reque nin 15 days of re	ce with these est is made to eccipt of a				
	INITIAL COMMENT You have agreed to receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st obul.htm The State delineated on the a	participate in the nsure orders co artment of Healt in 14-01, availal tate.mn.us/divs/ e licensing orde	nsistent with h ole at fpc/profinfo/inf rs are				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

**Electronically Signed** 01/04/17

TITLE

STATE FORM 6899 J6VE11 If continuation sheet 1 of 67

-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION :	(X3) DATE COMP	SURVEY
		00614	B. WING			C 08/2016
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
TALAHI	NURSING AND REHA	RCENTER	IVERSITY DR LOUD, MN 5	RIVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 000 2 565	Department of Hearyou electronically, is necessary for Star enter the word "correct. You must then State licensure procompletion date, the corrected prior to element of Minnesota Department of 12/05/16 throug Department's staffethe following correction that you and identify the date. In addition, an investigation of concompleted, and four MN Rule 4658.0408 Plan of Care; Use	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health.  In 12/08/16, surveyors of this visited the above provider and tion orders are issued. Our electronic plan of have reviewed these orders, e when they will be completed stigation of complaint and to be unsubstantiated.  Subp. 3 Comprehensive				1/17/17
		omprehensive plan of care personnel involved in the				
	by: Based on observati review, the facility for care was implement	on, interview, and document ailed to ensure the plan of ted for 4 of 5 residents (R41, reviewed who were		Completed		

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION		SURVEY PLETED
			A. BOILDING		<u> </u>	c
		00614	B. WING	·····		08/2016
NAME OF	PROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY,	STATE, ZIP CODE		
TALAHI	NURSING AND REHA	AR CENTER	JNIVERSITY DI CLOUD, MN (	RIVE SOUTHEAST 56304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 565	Continued From pa	age 2	2 565			
	dependent on staff (ADLs).	for activities of daily living				
	Findings include:					
	11/21/16, identified cognitively impaired from facility staff fo (ADL)'s. In addition ADL's during the MR41's plan of care, had an identified prelated to her (R41 plan identified R41 of 1 with ADL's and once a week as red the care plan noted.	nimum Data Set (MDS) date R41 was moderately d and required total assistant activities of daily living R41 had no rejection of IDS assessment period.  dated 10/06/16, noted R41 roblem for ADL self-care de 's) dementia. Further, the carequired extensive assistant was to receive a tub bath quested by R41. In additional R41 was to be provided a fall bath could not be	icit ure			
	12:41 p.m. R41 sta weekly scheduled l	with R41 on 12/05/16, at atted she had not received bath on a "regular basis" arecause she required assistar ith her ADL's.		``		
	received a tub bath 10/13/16, and 10/5 medical record, the	Form identified R41 had non 11/21/16, 11/10/16, /16. Upon review of R41' sere was no indication that Rewith bathing from 10/05/16	11			
	nursing assistant (I should be docume	n 12/07/16, at 6:07 a.m. NA)-J stated all of R41's ba nted on the body audit form ther, NA-J stated she was				

Minnesota Department of Health

STATE FORM 6899 J6VE11 If continuation sheet 3 of 67

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION		SURVEY PLETED
	00614	B. WING			C <b>08/2016</b>
NAME OF PROVIDER OR SUPPLIER TALAHI NURSING AND REHA	AR CENTER 1717 UNI		STATE, ZIP CODE RIVE SOUTHEAST 6304		
PRÉFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SECONDS) TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
was a "tough one"  When interviewed registered nurse (Freceiving at least of her care plan. Furth baths, "were not has audit forms.  During interview or director of nursing residents in the fact baths as directed by the following residents in the fact baths as directed by the following residents in the fact baths as directed by the following residents in the fact baths as directed by the following residents in the fact baths as directed by the following residents in the fact baths as directed by the following residents and Continence Evaluation indicated she was was unknown, unawas not motivated  R94's Individual Recare plan) dated 1 incontinent of bow rounds (every two indicated R94 was to reposition herse R94's nursing assisting instructed staff to the hours.  During continuous 6:00 a.m. to 8:34 a R94 was lying in her nightgown on.	Intuition of the past, but to bathe.  on 12/07/16, at 10:16 a.m.  RN)-D stated R41 should be one bath a week according to the RN-D stated R41's appening "according to the body on 12/07/16, at 11:26 a.m. with (DON) stated she was aware cility were not receiving their by the care plan.  Record undated indicated she neurological disease. A facility ation form dated 12/06/16, incontinent of bladder, onset able to sit on the toileted and to toilet.  Resident Care Plan (temporary 2/1/16, indicated she was all and bladder and toilet on hours). The care plan high risk for falls, was unable	2 565			

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STATE FORM 6899 J6VE11 If continuation sheet 4 of 67

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE	SURVEY LETED
71110 1 27111	or contribution	BENTH TO THE TOTAL BETTE	A. BUILDING:			
		00614	B. WING		12/0	; 8/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
TALAHI I	NURSING AND REHA	R CENTER	_	IVE SOUTHEAST		
		SAINT CL	OUD, MN 50			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILE OF T	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 4	2 565			
	assistant (NA)-E loc walked by. At 8:13 room stated he was provide R94 with ar re-entered the room which was moderat a small bowel move was red and excoris of the surface of the bottom was very red the area. NA-E stated and this was the first provided cares to R know when R94 was During interview 12 nurse (RN)-C stated	oked into R94's room and a.m. NA-E entered R94's checking on R94, but did not by cares. At 8:34 a.m. NA-E and removed R94's pad ely soaked with urine, and had ement. R94's entire peri- area ated (damage or remove part e skin). NA-E stated her d, and applied peri cream to ted he started at 6:00 a.m. at time during his shift he had 194. NA-E said he did not is last changed.				
	R87's admission Mi 10/4/16, identified F impaired, used a wl was at risk for falls activities of daily livi	inimum Data Set (MDS), dated R87 was mildly, cognitively heelchair for locomotion, and and dependent upon staff for ing.	•			
	high risk for falls an "Dycem non-slip ma at all times while re	ted 11/8/16 identified R87 at and included interventions for aterial to remain in wheelchair sident is up in chair." R87's rect staff to fasten the wedge elchair.				
	was seated in his w and no Dycem was During the evening again observed sea	on 12/7/16, at 1:36 p.m., R87 wheelchair while eating lunch. observed in the wheelchair. meal at 4:48 p.m., R87 was ated in his wheelchair, and no the wheelchair. During				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:	·		
		00614	B. WING		12/0	8/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
TALAHI I	NURSING AND REHA	R CENTER	VERSITY DR .OUD, MN 5	RIVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ige 5	2 565			
	observation on 12/8 seated in his wheel Dycem was observ	8/16, at 9:09 a.m. R87 was chair during breakfast, and no ed in R87's wheelchair.				
	assistant (NA)-F sta	ated R87 did not have any Ichair. NA-F stated she was being a fall intervention, or				
	director of nursing were communicate meetings. The DO	12/8/16 at 11:13 a.m., the (DON) stated fall interventions d to staff daily at morning N further stated staff were aber the interventions, and be				
		mplementation of resident uested, but not provided.	U			
	director of nursing inservice staff abou	THOD OF CORRECTION: The (DON) or designee could at implementing the care plants to ensure compliance.				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
2 570	MN Rule 4658.040 Plan of Care; Revis	5 Subp. 4 Comprehensive sion	2 570			1/17/17
	care must be review interdisciplinary tea physician, a registe for the resident, and disciplines as deter	A comprehensive plan of wed and revised by an am that includes the attending ered nurse with responsibility d other appropriate staff in remined by the resident's needs, practicable, with the				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE :	
			A. BUILDING:	<del></del>		
		00614	B. WING	<del></del>	12/0	8/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TALAHI	NURSING AND REHA	B CENTER	/ERSITY DR .OUD, MN 50	IVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 570	Continued From pa	age 6	2 570			
	guardian or chosen quarterly and within	resident, the resident's legal representative at least seven days of the revision of resident assessment required subpart 3, item B.				
	by: Based on observat review, the facility f plan of care for falls	ent is not met as evidenced ion, interview and document ailed to update the resident s with new interventions after a completed for 1 of 2 residents falls.		Completed		
	Findings include:	is identified on the face sheet	/			
	dated 12/8/16, includation failure, anxiety discussion Minimum	uded chronic respiratory order and weakness. R92's n Data Set (MDS) dated moderately impaired cognition.				
	The care area asset 11/22/16 identified shortness of breath and balance. The working with therap	essment (CAA) for falls dated R92 was at risk for falls due to a with activity, unsteady gait CAA also indicated R92 was by for strengthening and aking progress, and staff were		<b>'</b> O		
	was seated in her was room door. R92 wooxygen tubing to the anasal cannula in a cord, which lead	on 12/06/16 at 2:22 p.m., R92 wheel chair just outside her ore shoes and socks, had e right of the wheel chair, with place. Clipped to her shirt was directly to a TABS (a personal, ag safety) alarm, fastened to eel chair.				
	Review of an Inves	tigation Report dated 11/22/16				

Minnesota Department of Health

STATE FORM 6899 J6VE11 If continuation sheet 7 of 67

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	·	COMP	LETED
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		00614	B. WING			, 8/2016
		00014			12/0	0/2010
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TAL ALIL	MUDCING AND DELIA	D CENTED 1717 UNI	VERSITY DR	IVE SOUTHEAST		
IALAHII	NURSING AND REHA	SAINT CL	OUD, MN 5	6304		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	D BE	COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF	PRIATE	DATE
				DEI IOIENOT)		
2 570	Continued From pa	ige 7	2 570			
İ	indicated DOO had	an unwitnessed fall in her				
		an unwitnessed fall in her The interdisciplinary team				
		on to place a TABS (a				
		nt-detecting safety) alarm for				
	R92 when in wheel					
	1132 WHEIT III WHEET	chair of in bed.				
	The care plan revis	sed 11/21/16, identified R92				
		falls, and directed staff to:				
		t resident's needs; be sure the				
		each and encourage to use;				
		t to participate in activities that				
		or strengthening; ensure				
		appropriate footwear; follow				
		T (physical therapy) evaluate	1			
		are plan lacked the TABS				
	alarm intervention.	are plan lacited the mass				
	Review of the nursi	ng aide care sheets, undated,				
		ired stand by assist, was a				
		was to bet toiled every 2 hours,				
		liet. The sheet did not include				
	R92's fall intervention	on to use the TABS alarm.				
	During an interview	on 12/8/16 at 10:02 a.m.,				
	nursing assistant (N	NA)-I stated she always carried				
		ng sheet. After reviewing the				
		ere was nothing about R92's				
		[R92] is supposed to have the				
		ated she learns of changes to				
		s at the change of shift				
		uld be important to know the				
		ly if you help any new resident.				
	During interview on	12/8/16 at 10:15 a.m. the				
	director of nursing (	(DON) stated R92's working				
		ident's chart should have been				
		the aide cares sheets. The				
		t managers were responsible,				
		of getting that task				
	"completed and upo					

NAME OF PROVIDER OR SUPPLIER  TALAHI NURSING AND REHAB CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE  1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM-	ISTRUCTION (X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER  TALAHI NURSING AND REHAB CENTER  1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	С
TALAHI NURSING AND REHAB CENTER  1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	12/08/2016
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  SAINT CLOUD, MN 56304  SAINT CLOUD, MN 56304  PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE COME CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	GOUTHEAST
2 570 Continued From page 8 2 570	(EACH CORRECTIVE ACTION SHOULD BE COMPLÉTE CROSS-REFERENCED TO THE APPROPRIATE DATE
A facility policy titled Careplan revised 3/25/16, indicated it is the policy of Talahi Care Center that all residents have a Plan of Care which accurately reflects their needs and strengths, and guides staff in providing resident care. The policy further indicated an interdisciplinary team is responsible for the development of the care plan and nursing is responsible for safety and falls.  SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to care plan revisions. The DON or designee, could pervice training for all nursing staff related to the timeliness of care plan revisions. The quality assessment and assurance committee could perform random audits to ensure compliance.  TIME PERIOD FOR CORRECTION: Twenty-one (21) days.  2 800  MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements  Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements.  This MN Requirement is not met as evidenced by:	1/17/17

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Minnesota Department of Health STATE FORM

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPL IDENTIFICATION N			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	2. 302011011	.52		A. BUILDING:	<del></del>			
		00614		B. WING		12/0	; 8/2016	
NAME OF F	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
TALABLE	JUDGING AND DELIA	D CENTED	1717 UNI\	ERSITY DR	IVE SOUTHEAST			
IALAHII	NURSING AND REHA	b CENTER	SAINT CL	OUD, MN 50	5304			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENC MUST BE PRECEDED E SC IDENTIFYING INFORM	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 800	Continued From pa	ge 9		2 800				
2 800	Continued From particles and the state of th	on, interview and dailed to provide suffet assessed resider 11, R49, R94 and Res of daily living, 1 iewed for pressure (R3, R50, R80, R2) is (NA-A, NA-C, NAA, SM-B, SM-B, RNAT the lack of sufficient of the suffet	ficient of needs for 187) of 3 ulcers, and 0) and 10 B, TMA-A, 1-A) who ient nursing BEING  BEING  Be the plan of lents (R41, e y living e baths and sidents dent upon the timely of lopment for of	2 800	Completed			
	R3's quarterly Minir 8/23/16, identified F							

Minnesota Department of Health STATE FORM

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING: COMF			SURVEY LETED
			A. DUILDING	·		
		00614	B. WING			, 8/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
TALAHI I	NURSING AND REHA	R CENTER	/ERSITY DR OUD, MN 5	RIVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 800	Continued From pa	ge 10	2 800			
	required extensive	assistance with ADLs.				
	During interview on stated the facility lameet her needs tim staff were getting, "they had to rush threnough staff. R3 sturine that same day with toileting quickly feel, "Upset and fur R3's Device Activity 12/8/16, identified to times:  - On 11/25/16, at 11 for 22 minutes and - On 11/25/16, at 11 for 43 minutes and - On 11/27/16, at 11 for 18 minutes and - On 11/30/16, at 11 for 15 minutes and - On 11/30/16, at 61 for 21 minutes and - On 11/30/16, at 61 for 21 minutes and - On 12/2/16, at 8:359 minutes and 20 - On 12/2/16, at 12: was on for 47 minutes and 20 for 21 minutes and 20 for 30 minutes and 30 for 47 minutes and 30 minutes an	12/5/16, at 3:12 p.m. R3 cked sufficient nursing staff to ely. R3 stated the nursing Sloppy on cares," because ough them due to not having tated she was incontinent of a because she didn't get help a enough adding it made her ious."  A Report dated 11/24/16 to he following call light response 1:27 a.m. the call light was on 17 seconds; 46 a.m. the call light was on 35 seconds; 00 p.m. the call light was on 15 seconds; 58 a.m. the call light was on 25 seconds; 1:39 a.m. the call light was on 14 seconds; 52 p.m. the call light was on 8 seconds; 17 a.m. the call light was on 18 seconds;				

Minneso	<u>ta Department of He</u>	aith		1			-
	IT OF DEFICIENCIES OF CORRECTION		/SUPPLIER/CLIA TION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TALAHI I	NURSING AND REHA	B CENTER		/ERSITY DR OUD, MN 50	IVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 800	Continued From pa	ge 11		2 800			
	the bathroom and, a close" to having incomot enough staff to	ontinence bed	cause there is				
	R50's Device Activit 12/8/16, identified the times: - On 11/30/16, at 2: for 23 minutes and - On 11/30/16, at 11 for 19 minutes and - On 12/7/16, at 3:0 16 minutes and 32 - On 12/7/16, at 7:1 20 minutes and 41  R80's annual MDS	ne following content of the following content	all light response all light was on call light was on Il light was on for				
	had intact cognition assistance with ADI	and required					
	During interview on stated the facility wan R80 stated she had assistance before a on," to her bladder incontinence.	as not adequa I waited up to und at times ju	ately staffed. 30 minutes for ust has to, "Hang				
	R80's Device Activitiz/8/16, identified the times: On 11/30/16, at 6: for 22 minutes and On 12/7/16, at 7:1 minutes and 41 On 12/7/16, at 11: for 16 minutes and	ne following c 52 p.m. the ca 7 seconds; 0 a.m. the ca seconds and; 36 a.m. the ca	all light response all light was on Il light was on for				

R20's quarterly Minimum Data Set (MDS) dated

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` '	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	<del></del>	COMP	LETED
					C	<u>`</u>
		00614	B. WING			8/2016
		00014			12/0	0/2010
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ΤΔΙ ΔΗΙΙ	NURSING AND REHA	R CENTER 1717 UNIV	ERSITY DR	IVE SOUTHEAST		
IALAIIII	TOTIONIA AND TILLIA	SAINT CL	OUD, MN 50	6304		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	THAIL	DAIL
				,		
2 800	Continued From pa	ge 12	2 800			
	10/6/16 identified F	R20 had moderate cognitive				
	impairment.	tzo naa moderate oogintivo				
	pa					
	During interview on	12/5/16, at 6:11 p.m. R20				
		d not have enough staff to				
	provide timely assis	stance with his needs. R20				
		to wait up to 15 minutes for				
		eady asking for assistance.				
		he had fallen in the hallway				
		everal minutes before staff				
	responded to help h	nim.				
	STAFE CONCEDN	S WITH LACK OF STAFFING:				
	STAFF CONCERN	S WITH LACK OF STAFFING.				
	During interview on	12/6/16, at 2:06 p.m. nursing				
		ated the facility is typically				
		uple times a week," and				
	residents become ι	pset their cares are not				
		ely manner adding, "They				
	[residents] can sens	se it." NA-A stated the				
		not always completed if they		``^		
		d staff run around the facility,				
		their heads cut off," trying to				
	get cares complete	d.				
	When intervioused a	on 10/6/16 of 2:22 o NA C				
		on 12/6/16, at 2:28 p.m. NA-C				
		staff was, "Really short," some staffed with four aides on the				
		ility was not consistently				
		adding, "We're lucky if we				
		-C stated it was difficult to				
		assigned cares for residents,				
	•	se of the lack of staffing.				
		sidents, "Get really upset,"				
		nd cares aren't completed.				
		ed several staff had reported				
		ack of sufficient staff to the				
		d administration of the facility,				
		ust told. "We're working on it."				

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	NT OF DEFICIENCIES		R/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICA	ATION NUMBER:	A. BUILDING:		COMP	LETED
							,
		00614		B. WING			) 8/2016
		00014				12/0	0/2010
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
			1717 UNI\	ERSITY DR	IVE SOUTHEAST		
TALAHI	NURSING AND REHA	B CENTER		OUD, MN 50			
040.15	CLIMMA DV CTA	TEMENT OF DE		1			045)
(X4) ID PREFIX	(EACH DEFICIENC)	TEMENT OF DEF		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	REGULATORY OR L			TAG	CROSS-REFERENCED TO THE APPRO		DATE
					DEFICIENCY)		
2 800	Continued From no	ngo 12		2 800			
2 000	Continued From pa	ige 13		2 800			
	During interview on	12/6/16, at 2	2:45 p.m. NA-B				
	stated the memory						
	just two NA staff an						
	the memory care u	nit used to be	staffed with				
	three NA staff though	gh, however,	it was changed				
	because administra	ation felt peop	ole were just,				
	"Standing around d	own here." N	IA-B stated two				
	NA staff was not en	ough to care	for the residents				
	adequately or safel						
	aides because of th	ne behaviors	we have." NA-B				
	stated resident care						
	the lack of sufficien						
	[resident] not gettin						
	Further, NA-B state	ed these conc	erns regarding				
	the lack of staff had	d been, "Voice	ed strongly," to				
	managers and adm	ninistration.					
	When interviewed						
	trained medication	aide (TMA)-A	stated the facility				
	typically would only	staff, "The ba	are minimum of				
	what we need," and	d cares were	suffering as a		` ^ ^		
	result. TMA-A state						
	staffed, "At least tw						
	had been complain	ing about the	ir baths and other				
	cares not being cor	npleted.					
	During interview on						
	stated the memory						
	staffed with three N						
	NA-D stated if they						
	the day, then cares						
	good." Further, NA						
	motion and bathing						
	they were short sta						
	can get it, sometim	es you can't."	1				
	When interviewed						
	licensed practical n						
	residents had voice	ed concerns a	bout a lack of				

Minnesota Department of Health STATE FORM

NAME OF PROVIDER OR SUPPLIER  TALAHI NURSING AND REHAB CENTER  SAINT CLOUD, MN 56304   (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  2 800  Continued From page 14  sufficient staffing in the facility. LPN-C stated residents had particularly complained about their baths not being completed. Further, LPN-C stated she had reported concerns about a lack of staff to the administration.  During interview on 12/8/16, at 9:52 a.m. the human resources director (HRD) stated she was in charge of making the staffing assignments for the facility. The facility was nine NA staff with three nurses or TMA staff; however on the weekends there was less NA staff scheduled because baths weren't scheduled to be done then.  An undated Staff to Resident Ratio Goals chart was provided by HRD as the method for determining staff levels in the facility. The chart identified different groupings of resident population numbers along with a pre-determined		IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE : COMPI	
NAME OF PROVIDER OR SUPPLIER  TALAHI NURSING AND REHAB CENTER  1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  2 800 Continued From page 14  sufficient staffing in the facility. LPN-C stated residents had particularly complained about their baths not being completed. Further, LPN-C stated she had reported concerns about a lack of staff to the administration.  During interview on 12/8/16, at 9:52 a.m. the human resources director (HRD) stated she was in charge of making the staffing assignments for the facility. The facility used a griant and 'Just communicate with staff' to determine the stafting levels for each day. HRD stated the typical staffing for the facility was nine NA staff with three nurses or TMA staff; however on the weelends there was less NA staff scheduled because baths weren't scheduled to be done then.  An undated Staff to Resident Ratio Goals chart was provided by HRD as the method for determining staff levels in the facility. The chart identified different groupings of resident				231251140.			;
TALAHI NURSING AND REHAB CENTER  1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  2 800  Continued From page 14  sufficient staffing in the facility. LPN-C stated residents had particularly complained about their baths not being completed. Further, LPN-C stated she had reported concerns about a lack of staff to the administration.  During interview on 12/8/16, at 9:52 a.m. the human resources director (HRD) stated she was in charge of making the staffing assignments for the facility. The facility used a chart and 'Usus communicate with staff' to determine the staffing levels for each day. HRD stated the typical staffing for the facility was nine NA staff with three nurses or TMA staff; however on the weekends there was less NA staff scheduled because bath's weren't scheduled to be done then.  An undated Staff to Resident Ratio Goals chart was provided by HRD as the method for determining staff levels in the facility. The chart identified different groupings of resident			00614	B. WING			
XALAHI NURSING AND HEHAB CENTER   SAINT CLOUD, MN 56304     XALA ID   PREFIX   SUMMARY STATEMENT OF DEFICIENCIES   ID PREFIX (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DATE DATE DATE DATE DATE DATE D	NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
SUMMARY STATEMENT OF DEFICIENCIES   PREFIX   CEACH DEFICIENCY MUST BE PRECEDED BY FULL   PREFIX TAG   REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION   CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)    2 800   Continued From page 14   Sufficient staffing in the facility. LPN-C stated residents had particularly complained about their baths not being completed. Further, LPN-C stated stated she had reported concerns about a lack of staff to the administration.    During interview on 12/8/16, at 9:52 a.m. the human resources director (HRD) stated she was in charge of making the staffing assignments for the facility. The facility used a ghart and, "Just communicate with staff" to determine the staffing levels for each day. HRD stated the typical staffing for the facility was nine NA staff with three nurses or TMA staff; however on the wekends there was less NA staff scheduled because baths weren't scheduled to be done then.  An undated Staff to Resident Ratio Goals chart was provided by HRD as the method for determining staff levels in the facility. The chart identified different groupings of resident	TALAHI I	NURSING AND REHA	R CENTER				
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		residents had partic baths not being cor stated she had report staff to the adminis.  During interview on human resources of in charge of making the facility. The factor communicate with slevels for each day, staffing for the facil nurses or TMA staff there was less NAs weren't scheduled to was provided by Hild determining staff leidentified different general staff to was provided by Hild determining staff leidentified different general staff to was provided by Hild determining staff leidentified different general staff to was provided by Hild determining staff leidentified different general staff to was provided by Hild determining staff leidentified different general staff to was provided by Hild determining staff leidentified different general staff to was provided by Hild determining staff leidentified different general staff leidentified leidentified different general staff leidentified leidentifi	cularly complained about their impleted. Further, LPN-C orted concerns about a lack of tration.  12/8/16, at 9:52 a.m. the lirector (HRD) stated she was go the staffing assignments for cility used a chart and, 'Just staff" to determine the staffing. HRD stated the typical ity was nine NA staff with three fr; however on the weekends staff scheduled because baths to be done then.  Resident Ratio Goals chart RD as the method for vels in the facility. The chart groupings of resident				
		- NA for PM shift: 6	6.9 - 7.1				
- NA for AM shift: 8.6 - 8.9 (staff) - NA for PM shift: 6.9 - 7.1 - NA for night shift: 2.8 - 2.9		- Nurse/TMA for PN	/I shift: 3.5 - 3.6				
- NA for PM shift: 6.9 - 7.1		staff member (SM) staffed and baths, 'result. Further, SM	ous interview on 12/7/16, a -A stated the facility was short 'Usually don't get done," as a l-A stated residents had voiced bout the lack of staff in the				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S	
1					С	
		00614	B. WING		12/08	8/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TALAHI I	NURSING AND REHA	R CENTER	/ERSITY DR OUD, MN 5	IVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROID DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 800	Continued From pa	ge 15	2 800			
	few times a week."  During an anonymo	e complaints were heard, "A ous interview on 12/7/16, SM-B				
	"Couple times a we being answered slo provided consistent used to have pool shelpful because, "A there," to help with report these concertold, "Try to do your they were unaware	up working short staffed a, eek," which results in call lights wer and cares not being tly. SM-B stated the facility staff available which was it least [you] had that person cares. SM-B stated the staffers to the nurses, but are just best." Further, SM-B stated of anything being done by andle or address the lack of y.				
	SM-C stated the factor restructured the factor restructured the factor prior and each unit working. In addition used between the runit to complete bat SM-C stated complete cares was "More diand cares were sufficient stated several residuent heard about the recent months with the state of th					
	registered nurse (R several resident co- staffing, including a evening prior where minutes for assista- was, "An extended	on 12/8/16, at 10:51 a.m.  N)-A stated she had heard implaints about a lack of complaint as recently as the e a resident had to wait 17 ince. RN-A stated 17 minutes time," to wait for assistance.				

<u>Minneso</u>	ta Department of He	alth					
	IT OF DEFICIENCIES OF CORRECTION		R/SUPPLIER/CLIA ATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY LETED
	2. 302011011	.521111107		A. BUILDING:			
1		00614		B. WING		12/0	; 8/2016
NAME OF F	PROVIDER OR SUPPLIER	30014	OTDEET AD		STATE, ZIP CODE	1 12/0	J. 20 10
					IVE SOUTHEAST		
TALAHI N	NURSING AND REHA	B CENTER		OUD, MN 5			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 800	Continued From pa	ge 16		2 800			
	concerns with a lac forwarded to the sta of nursing (DON).						
	On 12/8/16, at 2:15 administrator were the facility. The facto determine staffin and acuity was also the staffing in the fabecause the care where the observed to where the care where the	interviewed a cility typically up g levels, howe considered. acility, "Was a ras good addivarrant an increase." The DC h staff during tare a, "Couple orward about added she did an to justify che facility. Furt the facility was care nursing djusted to reflect to the facility was care nursing th	bout staffing in used a guideline ever case load. The DON stated excellent," ing no issues had rease in staffing DN stated she the morning le of concerns," the lack of in't feel there was langing the ther, the was looking at g model and ect this.				
	A facility Nursing Dedated 12/2010, ider adequate staffing for directed staff to use assign scheduled nand attempt to replace.	ntified an obje or the nursing e daily check i ursing staff to	ective, "To provide floor," and in sheets to o work groups,				
	SUGGESTED MET director of nursing a current and ongoing if addition or relocat ensure all resident of	and/or design g staffing patt tion of staff is	ee could review erns to evaluate needed to				
	TIME PERIOD FOR (21) days.	R CORRECTI	ION: Twenty-one				

6899

Minnesota Department of Health STATE FORM

-	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BOILDING	·		C
		00614	B. WING			08/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY,	STATE, ZIP CODE		
TALAHI	NURSING AND REHA	AR CENTER	VERSITY DR LOUD, MN 5	RIVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	age 17	2 830			
2 830	MN Rule 4658.052 Proper Nursing Ca	0 Subp. 1 Adequate and re; General	2 830			1/17/17
	receive nursing car custodial care, and individual needs ar the comprehensive plan of care as de 4658.0405. A nurs of bed as much as written order from t	general. A resident must re and treatment, personal and I supervision based on and preferences as identified in e resident assessment and scribed in parts 4658.0400 and sing home resident must be out possible unless there is a the attending physician that the ain in bed or the resident in bed.				
	by: Based on observat review, the facility f supervision, and in to prevent accident (R87, R49, R75, R) addition, the facility properly fastened a	ient is not met as evidenced ion, interview, and document failed to ensure appropriate terventions were implemented thazards for 4 of 5 residents (37) reviewed for accidents. In a failed to ensure bed rails were and secured to the bed frame or 1 of 20 residents (R3) who is.		Completed		
	Findings include:					
	10/4/16, identified I	linimum Data Set (MDS), dated R87 was cognitively impaired, for locomotion, and was at risk				
		are Area Assessment (CAA), entified R87 was at risk for falls				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING	·		,
		00614	B. WING		_	8/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
TALAHI I	NURSING AND REHA	AR CENTER	VERSITY DR LOUD, MN 5	IVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	age 18	2 830			
	related to unsteady The CAA also indic maintaining balance	y gait and impaired balance. cated R87 had difficulty be while sitting, indicating R87 at times he will straighten his				
	to 11/26/16, identififacility since admis 10/22/16, indicated slid out of R87's whathe floor. The report sheet) was placed to the care plan.	eports, reviewed from 10/9/16 led R87 had seven falls in the sion. An incident report, dated I R87's wheelchair cushion had neelchair causing him to fall to rt indicated Dycem (non skid in R87's wheelchair and added				
	was a high risk for the intervention "Dy remain in wheelcha up in chair." R87's	ated 11/8/16, identified R87 falls. R87's care plan included ycem non-slip material is to air at all time while resident is care plan also indicated he eelchair cushion to assist with	S			
	was seated in his vand no dycem was During the evening again observed seadycem was present observation on 12/seated in his whee	on 12/7/16, at 1:36 p.m., R87 wheelchair while eating lunch. observed in the wheelchair. meal at 4:48 p.m., R87 was ated in his wheelchair, and no t in the wheelchair. During 8/16, at 9:09 a.m. R87 was lchair during breakfast, and no ed in R87's wheelchair.				
	assistant (NA)-F st in his wheelchair. N of dycem being a fa for R87's wheel chair	n 12/8/16, at 9:16 a.m. nursing ated R87 did not have dycem NA-F stated she was unaware all intervention, or was needed air. n 12/8/16, at 9:38 a.m.,				

Minnesota Department of Health
STATE FORM

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	COM			
, MAD I LAIN	O. COLLICION	IDENTIFICATION NOINDER.	A. BUILDING:	:		
<u> </u>		00614	B. WING		12/0	; 8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
TALAHI	NURSING AND REHA	R CENTER	/ERSITY DR .OUD, MN 5	RIVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 19	2 830			
	needed the dycem received the new w provided a non slip plan had not been redycem.  During interview on occupational therapthe dycem in his who cushion did not prosurface.  During interview on director of nursing (were communicate meetings. The DO	N)-C stated R87 no longer in his wheelchair once R87 heelchair cushion, which surface. RN-C stated the care revised to discontinue the 12/8/16, at 10:02 a.m. post (OT)-A stated R87 needed neelchair, and his wheelchair vide an appropriate non slip 12/8/16 at 11:13 a.m., the (DON) stated fall interventions d to staff daily at morning N further stated staff were ber the interventions, and be				
	9/1/16, directed all would be assessed interventions on the were to be implemented as a severely of the severe	S dated 10/15/16, indicated cognitively impaired, and a and set up with eating.  Atted 7/27/16, at 11:34 a.m. bicked up the coffee cup, was mouth spilled the hot coffee on eddened area appeared on tely "5' (inches) by 2", lap was eft leg 8" by 4", right leg 7" by				
	were to be implement of the control	S dated 10/15/16, indicated cognitively impaired, and and set up with eating.  ated 7/27/16, at 11:34 a.m. bicked up the coffee cup, was mouth spilled the hot coffee on eddened area appeared on tely "5' (inches) by 2", lap was				

Minnesota Department of Health

STATE FORM 6899 J6VE11 If continuation sheet 20 of 67

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	00614	B. WING			C <b>08/2016</b>	
NAME OF PROVIDER OR SUPPLIER  TALAHI NURSING AND REHAB	STREET AD  1717 UNIV		STATE, ZIP CODE IVE SOUTHEAST 5304			
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETE DATE	
room for breakfast. Oprior to getting meal. breakfast client grabbher mouth and accide her left arm and lap." in place for staff to fill half full and add ice oprior to serving, signal coffee carafes in easintervention.  R49's care plan dated resident required a modern cueing by staff to eat coffee fill cup half-full placing at the table, of the composition of the composi	e 20 Is sitting at table in dinning Client was given beverages While client was waiting for bed the cup, moved it toward entally spilled her coffee on Writer placed intervention I coffee/hot liquid containers cubes to cool to room temp age placed in front of the sit kitchen to remind staff of I and cool with ice prior to coffee should be luke-warm."  2/07/2016, at 12:34 p.m., A)-G provided R49 with her a cup of coffee 3/4 full. The coffee, and steam was m the top of the coffee cup.  12/07/16, at 12:40 p.m. NA-G ware of any interventions R49's coffee luke warm.  12/07/16, at 2:22 p.m., I)-B stated R49's coffee by adding water. RN-B re plan indicated ice should to keep it luke warm, not t that intervention for R49  IDENT ALTERCATION num Data Set (MDS) dated	2 830				

6899

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
			7. BOILDING	· · · · · · · · · · · · · · · · · · ·		,
		00614	B. WING		_	8/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TALAHI	NURSING AND REHA	R CENTER	VERSITY DR .OUD, MN 5	RIVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ige 21	2 830			
	impaired and depre	essed.				
	R75's care plan day had a behavior of r staff, related to der disturbance. The staff, related to der disturbance. The staff related to devel of coping and interation express feelings.  R37's quarterly MD was severely, cogniting diagnoses which in the A progress note day indicated R75 was another resident (Finstructed R75 to see resident's personal agitated. R75 walk sided upper body hand hit R75 in the hinjuries. R75 was a finshe couldn't keep room and no further the An Incident Report on 10/12/16, in the standing near R37, Staff offered R75 resident related to the standing near R37, Staff offered R75 resident related to the staff of	ted 09/29/16, indicated she epeatedly asking for certain nentia with behavior care plan directed staff to op more appropriate methods acting, and to encourage R75 appropriately.  S dated 11/1/16, indicated she itively impaired and had cluded dementia.  ted 10/12/16 at 3:58 p.m. observed to hover over (37). The note indicated staff tay away from the other space, because R37 was ed over and gave R37 a left ug. R37 swung their right fist nead. There were no apparent gain advised to go to her room to herself. R75 did go to her r behaviors were identified.  dated 10/13/16, indicated that afternoon staff had noted R75 showing concern for her.				
	some agitation tow was in Broda chair wheelchair) and R7 walker. She preced her a left sided hug make a fist with he	sonal space as R37 displayed ards others at this time. R37 (tilting and reclining '5 was ambulating using her led to walk up to R37 and gave R37 then proceeded to r right hand and strike R75.				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMPI	
					C	;
		00614	B. WING		12/0	8/2016
NAME OF F	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
TALAHI I	NURSING AND REHA	RCENIER	/ERSITY DR OUD, MN 50	IVE SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 22	2 830			
	the altercation with with interventions in after R37 struck R7	R37. There was no change nplemented for either resident, '5, to help reduce the risk of altercations and keep both				
	8/11/16 identified R required extensive daily living (ADL's). morbid obesity and weakness.	num Data Set (MDS) dated 3 was cognitively intact and assistance with activities of R3 had a diagnosis of severe generalized muscle	•			
	bed was fitted with approximately 24" ( height. The rails we with a screw. When	on 12/05/16, at 3:10 p.m. R3's bilateral, quarter side rails, inches) in length and 8" in ere fastened to bed frame, n grasped, each rail could be rth approximately 2" from the	S			
	registered nurse (R felt "very loose" and	12/05/16, at 3:19 p.m. with N)-E stated (R3's) side rails d was a safety risk for R3. at R3 frequently used the side sitting up in bed.		<b>'</b> O		
	stated the side rails	on 12/05/16, at 3:22 p.m. R3 had always been "very loose" use when they were that				
	registered nurse (R "wobbly" which place	12/05/16, at 6:53 p.m. the N)-A stated R3's side rails felt sed the resident at risk for falls n entrapment risk if the side oser.				
	On 12/08/16, at 1:0	3 p.m. MS stated the usual				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED	
			A. DOILDING		С	
1		00614	B. WING			) 8/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
TALAHI I	NURSING AND REHA	R CENTER	/ERSITY DR OUD, MN 5	RIVE SOUTHEAST		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	COMPLETE DATE
2 830	Continued From pa	ige 23	2 830			
	maintenance with o	s for facility staff to notify concerns with paper slips. there was no system in place nance.				
	identified staff mem rail is safe, provide	ed, "Side Rails" dated 6/11/16 nbers are to assess the side education to residents and are ufacture's instructions.				
	director of nursing of and reeducate all s procedures to ensuraccidents were rea implemented and p accident hazards.	THOD OF CORRECTION: The or her designee could review taff on the policies and are that all residents at risk for ssessed, interventions properly supervisor to prevent the director of nursing or her relop monitoring systems to impliance.	S			
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 835	MN Rule 4658.0520 Proper Nursing Car	0 Subp. 2 A Adequate and re; Criteria	2 835			1/17/17
	proper care. The cadequate and proper cylinderic of adequate and properties of adequate and properties of adequate and properties.	ate care and kind and lent at all times. Privacy must				
	by: Based on observati	ent is not met as evidenced ion, interview, and document ailed to provide baths and		Completed		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION :	(X3) DATE COMP	SURVEY PLETED	
			A. BOILDING	•		,
		00614	B. WING			8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
TALAHI	NURSING AND REHA	AR CENTER	VERSITY DF LOUD, MN 5	RIVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
	(R41, R94) reviewed staff for activities of Findings include:  R41's quarterly Mir 11/21/16, identified cognitively impaired for ADL's. In addition ADL's during the M	istance for 2 of 3 residents ed that were dependent upon f daily living (ADLs).  nimum Data Set (MDS) dated R41 was moderately d and required total assistance on, R41 had no rejection of IDS assessment period.  dated 10/06/16, noted R41 had				
	an identified proble related to her (R41 plan identified R41 assistance of one value a tub bath once a vaddition, the care provided a sponge be tolerated.	em for ADL self-care deficit 's) dementia. Further, the care required an extensive with ADL's and was to receive week as requested by R41. In blan noted R41 was to be bath when a full bath could not	75			
	12:41 p.m. R41 sta weekly scheduled l	with R41 on 12/05/16, at atted she had not received baths on a "regular basis "and cause she required assistance or her ADL's.		<b>`</b> O		
	received a tub bath 10/13/16, and 10/5 medical record, the	Form identified R41 had n on 11/21/16, 11/10/16, /16. Upon review of R41's ere was no documentation of s from 10/05/16 through				
	nursing assistant (I should be docume the bath book. Furt	n 12/07/16, at 6:07 a.m. NA)-J, stated all of R41's baths nted on the body audit form in ther, NA-J stated she was fusing a bath in the past and				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVE COMPLETED	
					С	
		00614	B. WING		12/08/201	6
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
TALAHI I	NURSING AND REHA	B CENTER	/ERSITY DR OUD, MN 5	IVE SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COM	X5) PLETE ATE
2 835	Continued From pa	ge 25	2 835			
	was a "tuff one "to I	oath.				
	registered nurse (R receiving at least or R41's baths "were the body audit form completed.  During interview on director of nursing (residents depender receiving their bath Review of a facility 10/2013, identified, bath per care plan a R94's Admission R6	policy titled, "Tub Bath" dated "all residents will receive a and the policy." ecord undated indicated she				
		had dementia and e. R94 was newly admitted, Minimum Data Set (MDS) was	~			
	dated 12/1/16, indic bowel and bladder An untitled and und	sident Care Plan (temporary) cated she was incontinent of and was toileted on rounds. lated nursing assistant care 4 was to be toileted every two				
	12/06/16, indicated bladder and wore a	uation assessment dated R94 was incontinent of brief. The assessment as unknown if R94 had an d not use the toilet.				
	6:00 a.m. to 8:34 a.	observation on 12/07/16, from m. (2 hours and 34 minutes) or bed on her right side with				

Millineso	ta Department of He	zailii				
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					C	:
		00614	B. WING			8/2016
						0,2010
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TALAHIN	NURSING AND REHA	R CENTER 1717 UNI	VERSITY DR	IVE SOUTHEAST		
IALAIIII	TOTIONIO AND TILITA	SAINT CL	OUD, MN 5	6304		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	)N	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	'RIAI E	DATE
				,		
2 835	Continued From pa	age 26	2 835			
	har nightgawn an	There was no staff for R94				
		is time. A 7:52 a.m. nursing				
ı		oked into R94's room and				
		a.m. NA-E entered R94's				
		s checking on R94, but did not				
		ares. At 8:34 a.m. NA-E				
		n and removed R94's pad				
		tely soaked with urine, and had				
		ement. R94's entire peri- area				
		ated (damage or remove part				
		e skin). NA-E stated her				
	bottom was very re	ed, and applied peri cream to				
		ated he started at 6:00 a.m.	•			
		st time during his shift he had				
	•	R94. NA-E said he did not				
	know when R94 wa	as last changed.				
	During interview 12	2/07/16, at 1:10 p.m. RN-C				
		continent of urine. RN-C	. ( )			
		s dependent upon staff and at				
		lown, and should be checked				
	and changed every	two hours.				
		THOD OF CORRECTION:				
		sing could in-service staff				
		eting bathing and toileting for				
		lity could develop a monitoring				
		ongoing compliance and report				
	tne findings to the (	Qualify Assurance Committee.				
	TIME DEDIOD FOR	P CORRECTION: Twonty one				
	(21) days.	R CORRECTION: Twenty-one				
	(LI) uays.					
			0.055			= =
2 900		5 Subp. 3 Rehab - Pressure	2 900			1/17/17
	Ulcers					
			II .			1

Minnesota Department of Health STATE FORM

E FORM 6899 J6VE11 If continuation sheet 27 of 67

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED	
		00614	B. WING			C <b>08/2016</b>
	PROVIDER OR SUPPLIER	R CENTER 1717 UN		STATE, ZIP CODE SIVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETE DATE
2 900	Subp. 3. Pressure comprehensive res of nursing services development of a nursing service sure sores undecondition demonstrate authenticates, that  B. a resident we receives necessary promote healing, promote he	sores. Based on the ident assessment, the director must coordinate the ursing care plan which  o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and tho has pressure sores y treatment and services to revent infection, and prevent veloping.  ent is not met as evidenced on, interview and document ailed to provide timely ting and repositioning to ressure ulcer development for each identified at risk of		Completed		

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING: (X3) DATE COMP			SURVEY PLETED		
		00614		B. WING			C <b>08/2016</b>
	PROVIDER OR SUPPLIER	B CENTER	1717 UNI		STATE, ZIP CODE  IVE SOUTHEAST  6304		
(X4) ID PREFIX TAG		TEMENT OF DEFICI	ENCIES ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 900	Continued From partial had very limited more of friction and shear score of 14 which in risk for developing and the care plan and the care the care and the care and the care the care and the care the care and the care and the care the care and the care and the care and the care the care and the care to plan and the care and the care the care and the care and the care the care and the care the care and the care to plan and the care and the care the care and the care the care and th	obility, with a potar. The assessment of the ass	nent had a as at moderate r.  In (temporary R94 was and was to be a did not be alcers.  I2/07/16, from a 34 minutes) ht side with taff for R94 a.m. nursing room and bred R94's a.m. NA-E R94's pad urine, and had antire peri- area or remove part tated her beri cream to at 6:00 a.m. s shift he had he did not be.m. She should are and beatment of side staff to be at a staff to be at				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED	
			A. BOILDING.			
		00614	B. WING			)8/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
TALAHI I	NURSING AND REHA	R CENTER	IVERSITY DR LOUD, MN 5	NVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	Continued From pa	ige 29	2 900			
	clinical conditions ir skin integrity, and p preventative measu	ncrease the risk for impaired pressure ulcers, to implement ures, and to provide ent modalities for wounds				
	director of nursing (inservice staff regal plan to ensure apprulcers, and then au	THOD OF CORRECTION: The (DON) or designee could rding implementation of a care ropriate treatment of pressure dit to ensure compliance.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
2 910	MN Rule 4658.0528 Incontinence	5 Subp. 5 A.B Rehab -	2 910			1/17/17
	have a continuous programment to reconnect unnecessary use of comprehensive results home must ensure A. a resident without an indwellinunless the resident that catheterization B. a resident where eives appropriate prevent urinary trace.	nce. A nursing home must program of bowel and bladder duce incontinence and the f catheters. Based on the ident assessment, a nursing that: tho enters a nursing home ag catheter is not catheterized is clinical condition indicates was necessary; and no is incontinent of bladder the treatment and services to out infections and to restore as ler function as possible.				
	This MN Requirements	ent is not met as evidenced				

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00614	B. WING			C <b>08/2016</b>
	PROVIDER OR SUPPLIER	R CENTER 1717 U		STATE, ZIP CODE RIVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 910	Continued From pa	ge 30	2 910			
	review, the facility fareassess a change	ion, interview, and document ailed to comprehensively in continence status for 1 of iewed for urinary incontinenc		Completed		
	Findings include:					
	08/04/16, indicated urine. The quarterly indicated R38 was to the control of the		<b>;</b>			
		ted 08/09/16, indicated he assistance of one for toileting	J.			
	thru 8/4/16, indicate of urine. A subsequ 10/26/16 thru 11/1/1 incontinent of urine	ocumentation from 7/28/16 ed R38 was never incontinent uent bladder assessment from 16, indicated R38 was nine times, which was a om his previous assessment	m			
	indicated R38 did n without incontinenc to toilet and was for assessment on 11/ continence was left from continent to fre there were no chan	ler assessment dated 11/1/16 of always void appropriately e, was independent, but slow regetful. This portion of R38's 1/16 to indicate changes in blank. Although R38 went equently incontinent of urine, ages to R38's interventions to event the incontinence.	V			

6899

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					SURVEY LETED	
		00614	B. WING		12/0	) 8/2016
	PROVIDER OR SUPPLIER	R CENTER 1717 UN		STATE, ZIP CODE RIVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 910	Continued From pa	ge 31	2 910			
	During interview 12 family member (FM and dribbled urine.  During observation assistant (NA)-F as was continent of uring interview 12 nurse (RN)-D stated but now was frequent RN-D stated she could be to the Bladder 7-Danurses on the floor completing the assessment director of made changes if new A facility policy titled Assessment will ensure the same appropriate treatment much normal bower possible.  SUGGESTED MET The director of nursual residents who new to assure they are retreatment/services toileting. The director of the same appropriate treatment to assure they are retreatment/services toileting. The director of the same appropriate treatment to assure they are retreatment/services toileting. The director of the same appropriate treatment to assure they are retreatment/services toileting. The director of the same appropriate treatment to assure they are retreatment.	/06/16, at 3:40 p.m. R38's l)-C stated R38 wore a pad 12/08/16, at 1:45 p.m. nursing sisted R38 to toilet and R38 ine.  /07/16, at 1:19 p.m. registered R38 was continent of urine, and the modern to				
		propriate care and services are	e			

6899

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
				A. BOILBIIVG.			
		00614		B. WING		12/0	08/2016
NAME OF I	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
TALAHI I	NURSING AND REHA	B CENTER		OUD, MN 50	IVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		CEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 910	Continued From page 32			2 910			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days.						
21235	MN Rule 4658.070 Director;Develop st			21235			1/17/17
	Subp. 2. Duties. T conjunction with the director of nursing s for:  C. the developractice for medica attending physician	e administrate services, must opment of state I care to prov	or and the st be responsible andards of				
	This MN Requirements: Based on interview facility failed to colladirector to address continuity for 1 of 1 receive medical carphysician.  Findings include:	and docume aborate with t concerns of presidents (R	ent review, the the medical physician 31) who did not	S	Completed		
	R31's admission m 8/26/16, indicated r						
	R31's hospital disclindicated she had be following a hospital also indicated a foll primary physician a R31's diagnosis list identified an admissinfection) along with nephropathy (kidne	peen admitted I stay related ow up appoint the facility in dated 12/7/sion diagnosina history of	d to the facility to leg pain, which ntment with her n one week. 16, further s of cellulitis (skin diabetes with				

6899

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE	SURVEY LETED
ANDILAN	OF CONTILOTION	IDENTIFICATION NOMBER.	A. BUILDING:	<del></del>		
		00614	B. WING		12/0	; 8/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
TALAHI	NURSING AND REHA	RCENTER	/ERSITY DR OUD, MN 50	IVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE	(X5) COMPLETE DATE
21235	Continued From pa	ge 33	21235			
	chronic obstructive pulmonary disease.					
	A review of physicia notes identified the	an and physician assistant (PA) following:				
	assessed by her pri The note indicated visits due to her "Ac conditions with multi "Given long-term pl facility will need to t On 10/17/16, 47 da R31 had an appoint different physician, assessed R31. The be contacting the fa concerning R31's n care." On 10/24/16, as a patient recomm	ceived a visit and was imary medical doctor (MD-B). that R31 needed monthly dvanced multiple comorbid tiple medications" and that acement in skilled nursing ransfer care."  ys after her last physician visit, tment to establish care with a MD-C outside the facility who note identified MD-C would acility to "Clarify the issue on-eligibility for in-facility MD-C declined to take R31 mending an Internal Medicine ed to place referral for the				
	an appointment with R31, the PA-A also patient due to her c	s after her admission, R31 had n a PA-A. After assessing declined to take R31 as a omplex medical history and nternal Medicine Physician.				
	R31 had an appoint	ys after she was admitted, tment with a MD-D outside the ted an assessment of R31 and by physician.				
	the facility had requ Director (MD)-A to f because they were	Note, dated 9/26/16, indicated ested the facility's Medical follow R31 starting 9/27/16, unable to find a physician for ote, dated 10/26/16, indicated				

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
					C	
		00614	B. WING		12/0	8/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TALAHI	NURSING AND REHA	R CENTER	OUD, MN 50	IVE SOUTHEAST 6304		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON .	(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)		COMPLETE DATE
21235	Continued From pa	ge 34	21235			
	the facility Medical follow R31 as a pat	Director-A had declined to ient.				
	R31's medical reco Medical Director-A of R31 in September within 30 days of her There was also no Director-A had been establish care with  During interview on stated she felt "Abar experience and "Director-A had been establish care with  During interview on stated she felt "Abar experience and "Director-A had been establish care with  During interview on stated she felt "Abar experience and "Director-Bar down" referring to r consistent physicial seen by the Medica he couldn't follow h R31 stated since th wouldn't see her, sl was "Just hoping and During interview on stated he wasn't ab due to her younger hadn't seen R31 in reviewed her chart referred to another unaware R31 had r physician in Septen care twice. The MD facility to contact hi stating he was ultim  During interview on of nursing (DON) si involved in finding of	rd lacked any indication the had completed an assessment er, when R31 was not seen er last physician assessment. indication the Medical n contacted to assist R31 to a primary physician.  12/7/16, at 3:50 p.m. R31 andoned and frustrated" by the dn't like the way things went not being followed by a n. R31 stated she hadn't been all Director, but had been told er due to age and insurance. The efacility's Medical Director ne "was hanging again" and nd praying things got better."  12/7/16, at 5:29 p.m. MD-A tole to take R31 as a patient age. He further stated he person in September, just and thought she was already physician. The MD-A was not been assessed by a niber or that she was denied to the modern and thought and thought she was already physician. The MD-A was not been assessed by a niber or that she was denied to the modern and thought she was already to the modern and thought she was already to the modern and thought she w				
	The facility's Medic	al Director Agreement,				

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE	SURVEY
7.1.12 . 2.1.1	0. 0020		A. BUILDING:	:		
		00614	B. WING		12/0	) 8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY,	STATE, ZIP CODE		
TALAHI	NURSING AND REHA	B CENTER	VERSITY DR LOUD, MN 5	IVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21235	reviewed 1/29/16, i include the "Overal in the facility to ensappropriateness of to residents."  SUGGESTED MET The Medical Direct review, and/or revisensure appropriate being provided by publication of the policies Director or designed systems to ensure TIME PERIOD FOR	dentified the responsibilities to I coordination of medical care sure the adequacy and the medical services provided the medical services provided.  THOD OF CORRECTION: or or designee could develop, see policies and procedures to resident care and services are obysicians. The Medical could educate all appropriate and procedures. The Medical see could develop monitoring ongoing compliance.  R CORRECTION: 30 DAYS				1/17/17
	A. A resident metal physician at least of 90 days after admission medically necessar considered timely if the date the visit was the date the visit was a seed on interview facility failed to ensprovided at least or	ey of physician evaluations. Thust be evaluated by a since every 30 days for the first sesion, and then whenever ry. A physician visit is fit occurs within ten days after as required.  The ent is not met as evidenced and document review, the sure that physician visits were not every 30 days for the first sesion for 1 of 5 residents (R31)		Completed		

Minnesota Department	of Health	1		r	
STATEMENT OF DEFICIENCIES	· /	(X2) MULTIPI	LE CONSTRUCTION	(X3) DATE	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	:	COMPI	LETED
				С	;
	00614	B. WING			8/2016
NAME OF PROVIDER OR SUPP	VI IER STDEET A	DDRESS CITY	STATE, ZIP CODE		
NAME OF THOUBERORS			RIVE SOUTHEAST		
TALAHI NURSING AND R	CHAR CENTER	LOUD, MN 5			
CLIMMAE		-	1	DNI .	2/5)
	Y STATEMENT OF DEFICIENCIES HENCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
	OR LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI	PRIATE	DATE
			DEFICIENCY)		
21290 Continued From	m page 36	21290			
who were now	ly admitted to the facility				
willo welle flew	who were newly admitted to the facility.				
Findings include	Findings include:				
DOM: 1 : :					
	on minimum data set (MDS), dated	1			
0/20/10, Indica	ted no cognitive impairment.				
R31's hospital	discharge report, dated 8/19/16,				
	nad been admitted to the facility				
	spital stay related to leg pain. R31'	s			
,	dated 12/7/16, identified an				
	noses of cellulitis (skin infection)				
	story of diabetes with nephropathy				
	e), heart failure, and chronic monary disease.				
obstructive pur	monary disease.				
A review of phy	ysician and physician assistant (PA				
notes identified					
	R31 received a visit and was				
	er from her primary physician. The that R31 needed monthly visits du				
	ed multiple co-morbid conditions	=			
	redications" and that "Given		<b>'</b>		
	ement in skilled nursing facility will				
need to transfe					
	47 days after her last physician				
	an appointment to establish care physician outside the facility.				
	ointment, an assessment was				
	the physician later declined to				
	a patient. The physician visit did no	ot			
	days, but 47 days since her				
8/31/16 initial p					
5					
	w on 12/7/16, at 12:27 p.m.				
	se (RN)-A stated it had been R31 a new physician, when her				
	ian wouldn't follow her anymore.				

6899

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMPI	
					С	
		00614	B. WING		12/0	8/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TALAHI	NURSING AND REHA	RCENTER	/ERSITY DR OUD, MN 50	IVE SOUTHEAST		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	COMPLETE DATE
21290	Continued From pa	ge 37	21290			
	primary physician we when admitted to the the facility policy. Recontinuity in physicial contact if there were described by the facility policy. But the facility policy is admitted to the facility policy primary physicial described by the facility primary physician for status in the facility when admitted to the facility policy primary physician for status in the facility policy. The facility policy primary physician for status in the facility policy.	uation was rare that the would stop seeing a patient ne facility, and was unaware of N-A stated (R31) needed tans so staff knew who to be medical problems.  12/7/16, at 3:50 p.m. R31 andoned and frustrated" by the dn't like the way things went not being followed by a n.  12/7/16, at 5:13 p.m. director tated it had been difficult to R31 due to her long term and her younger age. didn't think R31 was without				
	director (MD)-A sta not had a consister nursing home. It wa R31's primary phys her until she had be physician, but indic responsible for ove A facility copy of the States Bill of Rights facility would seek a	e Combined Federal and s, dated 11/28/16, directed the alternate physician services to if appropriate and adequate				
	nursing (DON) or d	of Correction: The director of esignee could work with the d administrator to ensure				

6899

	NT OF DEFICIENCIES OF CORRECTION		R/SUPPLIER/CLIA CATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY
				A. BUILDING:		,	,
		00614		B. WING		12/0	)8/2016
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TALAHI	NURSING AND REHA	B CENTER		/ERSITY DR OUD, MN 50	IVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC' REGULATORY OR L		CEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21290	Continued From pa	ıge 38		21290			
	physician coverage the facility. The ad could also perform determine if the phy provided. Time Period for Co	ministrator, E audits of res ysician servic	OON or designee ident records to ces had been				
	days.						
21390	MN Rule 4658.080  Subp. 4. Policies a control program mu procedures which particles and collection to identify residents;  B. a system for control of outbreak.  C. isolation and reduce risk of transport of transport of transport of the control and control and control and control and control and control of transport	and procedurest include porovide for the based on syy nosocomial or detection, in soft infectious different proceduration in inducation in introl; ealth programam, a tuberce 18.0810, and	res. The infection olicies and he following; stematic data infections in he diseases; systems to difectious agents; hection he including an eulosis program as policies and	21390			1/17/17
	the prevention and F. the develope employee health po practices, including defined in part 465 G. a system fo H. a system fo products which affed disinfectants, antist incontinence produ I. methods for current standards of	treatment of ment and impolicies and into a tuberculos 3.0815; r reviewing a r review and ect infection of eptics, gloves cts; and maintaining a	infections; blementation of fection control sis program as ntibiotic use; evaluation of control, such as s, and				

6899

AND PLAN OF CORRECTION    Dentification Number:   A. Building:   C.		NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X3) WI II TIDI	F CONSTRUCTION	(X3) DATE	SLIBVEV
NAME OF PROVIDER OR SUPPLIER  TALAHI NURSING AND REHAB CENTER  TALAHI NURSING AND REHAB CENTER  TALAHI NURSING AND REHAB CENTER  SUMMARY STATEMENT OF DEFICIENCIES SAINT CLOUD, MN 56304  PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG  This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to implement a comprehensive infection control program to include consistent tracking, trending and analysis of illnesses and infections to prevent potential spread to others. This had potential to affect all 70 residents, staff and visitors to the facility. In addition, the facility failed to ensure staff completed a dressing change with appropriate hand hygiene for 1 of 1 residents (R39) observed during wound cares.  Findings include:  A binder was provided by the director of nursing				` '		( - /	
NAME OF PROVIDER OR SUPPLIER  TALAHI NURSING AND REHAB CENTER  TALAHI NURSING AND REHAB CENTER  SUMMARY STATEMENT OF DEFICIENCIES  PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to implement a comprehensive infection control program to include consistent tracking, trending and analysis of illnesses and infections to prevent potential spread to others. This had potential to affect all 70 residents, staff and visitors to the facility. In addition, the facility failed to ensure staff completed a dressing change with appropriate hand hygiene for 1 of 1 residents (R39) observed during wound cares.  Findings include:  A binder was provided by the director of nursing				, DOILDING.		,	,
TALAHI NURSING AND REHAB CENTER  1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  21390  Continued From page 39  This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to implement a comprehensive infection control program to include consistent tracking, trending and analysis of illnesses and infections to prevent potential spread to others. This had potential to affect all 70 residents, staff and visitors to the facility. In addition, the facility failed to ensure staff completed a dressing change with appropriate hand hygiene for 1 of 1 residents (R39) observed during wound cares.  Findings include:  A binder was provided by the director of nursing			00614	B. WING	<del></del>		
California   Completed   Com	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
(X4) ID SUMMARY STATEMENT OF DEFICIENCES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  21390 Continued From page 39  This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to implement a comprehensive infection control program to include consistent tracking, trending and analysis of illnesses and infections to prevent potential spread to others. This had potential to affect all 70 residents, staff and visitors to the facility. In addition, the facility failed to ensure staff completed a dressing change with appropriate hand hygiene for 1 of 1 residents (R39) observed during wound cares.  Findings include:  A binder was provided by the director of nursing	TALALI	NUDCING AND DELIA	D CENTED 1717 UNIV	ERSITY DR	IVE SOUTHEAST		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  21390 Continued From page 39  This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to implement a comprehensive infection control program to include consistent tracking, trending and analysis of illnesses and infections to prevent potential spread to others. This had potential to affect all 70 residents, staff and visitors to the facility. In addition, the facility failed to ensure staff completed a dressing change with appropriate hand hygiene for 1 of 1 residents (R39) observed during wound cares.  Findings include:  A binder was provided by the director of nursing	IALAHI	NURSING AND REHA	SAINT CL	OUD, MN 5	6304		
This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to implement a comprehensive infection control program to include consistent tracking, trending and analysis of illnesses and infections to prevent potential spread to others. This had potential to affect all 70 residents, staff and visitors to the facility. In addition, the facility failed to ensure staff completed a dressing change with appropriate hand hygiene for 1 of 1 residents (R39) observed during wound cares.  Findings include:  A binder was provided by the director of nursing	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	_D BE	(X5) COMPLETE DATE
by: Based on interview and document review, the facility failed to implement a comprehensive infection control program to include consistent tracking, trending and analysis of illnesses and infections to prevent potential spread to others. This had potential to affect all 70 residents, staff and visitors to the facility. In addition, the facility failed to ensure staff completed a dressing change with appropriate hand hygiene for 1 of 1 residents (R39) observed during wound cares.  Findings include:  A binder was provided by the director of nursing	21390	Continued From pa	ge 39	21390			
(DON) on 12/5/16, with different tabbed sections representing each specific month of infection control monitoring. The following information was identified:  SEPTEMBER 2016:  An Order Listing Report dated 12/5/16, identified four different residents had received antibiotics during the month for different diagnoses which included a urinary tract infection, a dental infection, pneumonia, and a, "Rash." The report lacked any dates of symptom onset or resolution, room numbers, organisms, or if the infection was determined to be community or in-house acquired.  A single Employee Call-In Report dated 9/1/16, identified an employee called in ill with symptoms of, "Puking, shaky [and] a fever."  In addition, several Centracare Laboratory	21390	This MN Requirements: Based on interview facility failed to imprinfection control protracking, trending a infections to prever This had potential trand visitors to the failed to ensure statchange with appropresidents (R39) observed the failed to ensure statchange with appropresidents (R39) observed the failed to ensure statchange with appropresidents (R39) observed the failed to ensure statchange with appropresidents (R39) observed the failed to ensure statchange with appropresidents (R39) observed the failed to ensure statchange with appropresidentified:  SEPTEMBER 2016  An Order Listing Refour different resided during the month failed to determine the failed to be considered.  A single Employee identified an employee identi	and document review, the lement a comprehensive ogram to include consistent and analysis of illnesses and at potential spread to others. The facility of completed a dressing oriate hand hygiene for 1 of 1 served during wound cares.  The following information was or different diagnoses which ract infection, a dental ia, and a, "Rash." The report of symptom onset or resolution, anisms, or if the infection was ommunity or in-house  Call-In Report dated 9/1/16, yee called in ill with symptoms and] a fever."	21390	Completed		

Minnesota Department of Health

STATE FORM 6899 J6VE11 If continuation sheet 40 of 67

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BOILDING.				
		00614	B. WING			8/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE			
TALAHI I	NURSING AND REHA	R CENTER	/ERSITY DR OUD, MN 5	IVE SOUTHEAST 6304			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
21390	•	ge 40 tted 9/1/16, through 9/30/16,	21390				
	identified different of specimens. The residents had urine same bacteria, how on the date of sympinfection was determined.  The collected data analysis of the infection determine the causting specimens.	ated 9/1/16, through 9/30/16, cultures of collected sports identified three different samples cultured with the vever lacked any information of the mined to be community or lacked any trending or ctions in the facility to e of each infection or if they were spreading in the facility.					
	six residents had re month for different chronic pain syndro severe sepsis. The symptom onset or r room numbers, or i	eport dated 12/5/16, identified eceived antibiotics during the diagnosis which included ome, pneumonia, yeast, and e report lacked any dates of resolve, organism cultures, if the infection was determined	S				
	An undated Infection resident had an infection 10/27/16, and listed number. The form type of infection has spacing to place a company symptoms. However, blank and no data of type of infection the symptoms which has	in-house acquired.  In Report Form identified a section noted to begin on the determinant of the rame, sex and room had spacing to identify what doccurred including additional checkmark in corresponding er, all of these fields were left was entered to identify what e resident had or any addeveloped.					
	different resident w	ith their name, unit and date of r lacked any further					

_	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION :	(X3) DATE SURVEY COMPLETED	
			7. BOILDING	·		
		00614	B. WING		12/0	08/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TALAHI	NURSING AND REHA	AR CENTER	IIVERSITY DE CLOUD, MN 5	RIVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
21390	Continued From pa	age 41	21390			
	blank and no data	emainder of the form was left was entered to identify what e resident had or any ad developed.				
	analysis of the infedetermine the caus	lacked any trending or ctions in the facility to se of each infection or if they were spreading in the facility.				
	NOVEMBER 2016					
	nine residents had month for different urinary tract infection a, "Rash." The rep symptom onset or organism cultures,	eport dated 12/5/16, identified received antibiotics during the diagnosis which included on, bronchitis, pneumonia, and ort lacked any dates of resolution, room numbers, or if the infection was ommunity or in-house				
	infections in the fac	ny trending or analysis of the cility to determine the cause of they had potential to, or were cility.		••		
	There was no furth of the identified mo	er information provided for an onths of data.	у			
	director of nursing had been in charge employed at the factorized process of being recoversee. Further, to control program lactorized	on 12/7/16, at 3:36 p.m. the (DON) stated the person who e of the program was no longe cility and they were in the eassigned to someone else to the DON stated the infection cked consistent monitoring, is of the collected data adding,				

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	LE CONSTRUCTION		SURVEY PLETED
		00614	B. WING			C
		00614	B. WING		12/0	08/2016
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
TALAHI	NURSING AND REHA	R CENTER	IIVERSITY DR CLOUD, MN 5	RIVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21390	Continued From pa	ae 42	21390			
	"We have to come "Have better trackir facility]." Further, the aware the program components for the	to a better system," and, ng of that [infections in the ne DON stated she had been				
	administrator stated for infections during throughout the wee processes for track of infection are bein pattern."	d staff were, "Always watching their regular meetings k, however do not start any ing or trending unless pattern ng noted, "I look for the				
	2/16/16, identified a "Help prevent the d of disease and infection and included, "Surveillar collection," and have investigation, and c infectious disease." summaries of the irrand analyzed by the with findings being	control Program policy dated in objective which included, evelopment and transmission ction." The policy identified if the facility program which nee based on systemic dataing, "A system for detection, ontrol of outbreaks of Further, the policy identified affections were to be compiled to infection control committee, communicated to determine it or procedures were required.				
	7/12/16, identified F a diagnosis of cong right above the kne R39's significant ch R39 had an unstag left heel and anothe R39's treatment ad physician order on change to left heel:	inimum Data Set (MDS) dated 339 was cognitively intact with lestive heart failure and an e amputation. On 10/17/16, ange in status MDS identified eable pressure ulcer on R39's er on his coccyx.  ministration record identified a 11/04/16, for "Dressing Clean open area with normal with Melgisorb dressing.	1 3 3			

Minneso	ota Department of He	ealth				
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00614	B. WING		12/0	; 8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TALAHI	NURSING AND REHA	R CENTER	VERSITY DR OUD, MN 50	IVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21390	Continued From pa	ge 43	21390			
	Change daily and on During observation practical nurse (LPI gloves. With her clesoiled bandage from in the trash. Without gloves, LPN-A-A observation accidentally droppe the bandage off the her (LPN-A's) pock dressing without first With her same soiled R39's left heel, R39's heel and then remote than proceeded to when the phase of the lafter she (LPN dug in her pocket where the lafter she (LPN dug in her pocket where the lafter she in the lafte	on 12/07/16, licensed N)-A donned a set of clean ean gloves, LPN-A took off them R39's left heel and threw it at first removing her soiled obtained a new bandage and it on the floor. She grabbed efloor and obtained a pen from et to mark a date on the st removing her soiled gloves. LPN-A irrigated sure ulcer. After irrigating placed his clean heel unto it. With her same soiled gloves, lean dressing over R39's left oved her soiled gloves. LPN-A wash her hands in R39's left least the ground and with her gloved hands. LPN-A hould have not touched the eated because it increased fection. Further, LPN-A stated in on a clean set of gloves pressure ulcers because there is "contaminating" the area sk of infection.  12/07/16, at 11:18 a.m. the finursing (ADON)-A stated is could contaminate the area isk of infection to R39's				

6899

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SU AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A PLUI DING: COMPLET		SURVEY LETED			
7.11.2 1 27.114	or connection	BENTH TOX THOM TOWN BETTE	A. BUILDING:	<del></del>		
		00614	B. WING		12/0	) 8/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
TALAHI I	NURSING AND REHA	R CENTER	/ERSITY DR OUD, MN 50	IVE SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21390	Continued From pa	ige 44	21390			
	treatment as it coul to the pressure ulce	es during pressure ulcer d increase the risk of infection er on R39's left heel. nand hygiene was requested, aring the survey.				
	director of nursing of infection control proprocedures are estregarding policy an ensure compliance	THOD OF CORRECTION: The or designee could review their ogram to ensure policies and ablished, inservice staff d procedure, and audit to				
21475	Subpart 1. General home must have an department or progrelated social service nursing home must collaborate with out who is in need of acceptance.	5 Subp. 1 Social Services: ents Il requirements. A nursing n organized social services iram to provide medically ces to each resident. A t make referrals to or tside resources for a resident dditional mental health, or financial services.	21475			1/17/17
	by: Based on interview facility failed to provervices to assist re	ent is not met as evidenced and document review, the vide the necessary social esidents in finding a physician (R31) who did not have a		Completed		

Minnesc	ta Department of He	alth					
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SU IDENTIFICATION			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00614		B. WING		12/0	) 8/2016
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TALAHI	NURSING AND REHA	B CENTER		/ERSITY DR .OUD, MN 56	IVE SOUTHEAST 6304		
(X4) ID PREFIX TAG		TEMENT OF DEFICIE MUST BE PRECEDI SC IDENTIFYING INF	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21475	Continued From pa	ge 45		21475			
	Findings include:						
	R31's admission m 8/26/16, indicated r						
	R31's hospital dischindicated she had be following a hospital also indicated a foll primary physician a R31's diagnosis list identified an admissinfection) along with nephropathy (kidne chronic obstructive). Review of physiciar notes identified the On 8/31/16, R31 re assessed by her properties of the respective of the conditions with multiple of the respective of the re	leen admitted to I stay related to low up appointment the facility in oral dated 12/7/16, sion diagnosis or a history of diagnosis or a history of diagnosis or and physician following:  I ceived a visit and that R31 needed divanced multiple tiple medications acement in skilled.	the facility leg pain, which ent with her ne week. further f cellulitis (skin betes with rt failure, and ase. assistant (PA) d was octor (MD-B). d monthly e comorbid s" and that				
	On 10/17/16, 47 da R31 had an appoint different physician, assessed R31. The be contacting the faconcerning R31's n care." On 10/24/16, as a patient recomprovider, and offere facility.  On 11/3/16, 76 days an appointment with	ys after her last tment to establis MD-C outside the note identified acility to "Clarify on-eligibility for MD-C declined mending an Inte- ed to place refer	sh care with a ne facility who MD-C would the issue in-facility to take R31 rnal Medicine ral for the				

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00614		B. WING			C <b>08/2016</b>
	PROVIDER OR SUPPLIER NURSING AND REHA	B CENTER	1717 UNI	-	STATE, ZIP CODE IVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIE MUST BE PRECEDE SC IDENTIFYING INFO	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
21475	Continued From particular R31, the PA-A also patient due to her or recommended an Intercommended and Intercommended Intercommended and Intercommended Int	declined to take omplex medical nternal Medicine ys after she was tment with a MD red an assessment y physician.  It diacked any incertain a primary physician in Septiated he was unawed by sician in Septiated he was unawed by sician in Septiated he responsibility of continue care used the responsibility of the responsibility in	history and Physician.  admitted, Doutside the ent of R31 and dication social sal to ian while a p.m. medical vare R31 was tember or that care twice. Yof R31's until a dowever, after ary physician, is social opropriate as a.m. social propriate as a.m. social propriate as a.m. social retypically unlike R31's the nursing new to thave any sian.  ECTION: d review ocedures ervices. educated on	21475			

STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					C	
		00614	b. WING		12/0	8/2016
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TALAHI N	IURSING AND REHA	RCENTER	OUD, MN 50	IVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21475	social service need in the deficiency, wi maintained. Other for social service need could be developed results shared with Assessment & Assi on-going compliant TIME PERIOD FOF (14) days.  MN Rule 4658.1318 Usage; Monitoring Subp. 2. Monitoring Monitor each reside unnecessary drug to home's policies and pharmacist must reresident's attending physician does not home's recomment adequate justification believes the resider adversely affected, matter to the medical director is the medical director is the medical director physician does not the order and if the change the order, the review to the Qualit (QAA) committee rethe attending physician physician does not the order and if the change the order, the attending physician physician physician does not the order and if the change the order, the attending physician physician does not the order and if the change the order, the attending physician physician does not the order and if the change the order, the attending physician physician does not the order and if the change the order, the attending physician does not the order and if the change the order, the attending physician does not the order and if the change the order, the attending physician does not the order and if the change the order and	de toward supporting the s of the individual(s) identified th supporting documentation residents could be evaluated eds. An auditing system and implemented, with the facility's Quality grance committee, to ensure ed.  R CORRECTION: Fourteen  S Subp. 2 Unnecessary Drug  G. A nursing home must ent's drug regimen for usage, based on the nursing a procedures, and the port any irregularity to the physician. If the attending concur with the nursing dation, or does not provide on, and the pharmacist ent's quality of life is being the pharmacist must refer the all director for review if the not the attending physician. If redetermines that the attending have adequate justification for attending physician does not no matter must be referred for y Assurance and Assessment equired by part 4658.0070. If cian is the medical director, macist shall refer the matter	21475			1/17/17

6899

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				_	C	;
		00614	B. WING			8/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TALAHI I	NURSING AND REHA	R CENTER	/ERSITY DR OUD, MN 50	IVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRES OF THE APPROPRIED TO THE A	D BE	(X5) COMPLETE DATE
21540	Continued From pa	ge 48	21540			
21540	This MN Requirements: Based on interview facility failed to ensinterventions and becompleted prior to a medications for 1 of for unnecessary medications include:  R80's quarterly Min 08/11/16, indicated impairment with a cand anxiety disorder.  R80's Care Area As 11/15/16, noted R8 psychosis and requione with activities of R80's care plan dath had an identified pranti-anxiety medical anxiety disorder." In monitor/record occi symptoms and doc There was no indicated intervention.	ent is not met as evidenced , and document review, the ure non-pharmacological ehavior monitoring were administering anti-anxiety f 5 residents (R80) reviewed edications.  imum Data Set (MDS) dated R80 had no cognitive diagnosis of major depressive er.  ssessment (CAA) dated 0 had no behaviors or irred extensive assistance of of daily living (ADL's).  sed 02/23/16, indicated R80 oblem of, "Resident uses ations [Ativan] related to interventions for R80 included; currence for behaviors ument per facility protocol. ation of how R80's exhibited	21540	Completed		
	to 2:28 p.m. R80 exanxiety. During obs	on 12/6/16 between 1:45 p.m. chibited no outward signs of servation on 12/7/16 from 6:00 R80 presented no signs of				
	(MAR) indicated R8	edication administration record 80 had an order for lorazepam o treat anxiety) 0.25 milligrams				

Minnesota Department of Health

STATE FORM 6899 J6VE11 If continuation sheet 49 of 67

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00614	B. WING			C <b>08/2016</b>
	PROVIDER OR SUPPLIER	R CENTER 1717	ET ADDRESS, CITY, UNIVERSITY DE	RIVE SOUTHEAST	·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21540	(mg) tablet every 6 disorder. Further, the were to document and non-pharmacologic effectiveness before medication.  Review of the MAR In August 2016, R8 lorazepam on 2 differisodes did not idenon-pharmacologic In September 2016 lorazepam on 10 diabove episodes nonon-pharmacologic attempted prior to the In October 2016, R lorazepam, and signon-pharmacologic attempted prior to the There was no indicate monon-pharmacologic attempted prior to the There was no indicate monon-pharmacologic attempted prior to the In November 2016, lorazepam and signon-pharmacologic attempted prior to the medication.  Review of R80's phoon 01/20/16, the coindicated facility stabehaviors, non-pharmacologic attempted prior to the coindicated facility stabehaviors, non-pharmacologic attempted prior, non-pharmacologic attempted prior to the coindicated facility stabehaviors, non-pharmacologic attempted prior, non-pharmacologic attempted prior to the coindicated facility stabehaviors, non-pharmaco	hours as needed for anxiet ne order specified facility stages of anxiety, all interventions used and it e administering the identified the following:  O took her as needed erent occasions of which be entify any signs of anxiety of all interventions used.  R80 took her as needed fferent occasions. During signs of anxiety, or all interventions were he use of the medication.  80 received 7 doses of ans of anxiety, or all interventions were he use of the medication.  81 received 7 doses of anxiety, or all interventions were he use of the medication.  82 received 7 doses of anxiety, or all interventions were he use of the medication.	aff ss	DEFICIENC		
		14/16, the CP again indicat on R80's lorazepam neede				

6899

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMPI	
					С	
		00614	B. WING		12/0	8/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TALAHI	NURSING AND REHA	R CENTER	/ERSITY DR OUD, MN 50	IVE SOUTHEAST		
(X4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	COMPLETE DATE
21540	Continued From pa	ge 50	21540			
	to include behavior interventions.	s and non-pharmacological				
	registered nurse (Rexpected to docum interventions and by the as needed loraze there was no behave non-pharmacological after reviewing R80 When interviewed on nursing (DON) statistically staff to document interventions and by effectiveness of the is no rational for the current dose for R80 Review of an undatal "Psychotropic Media"	al interventions attempted o's medical record.  on 12/07/16, the director of ed it was important for facility on-pharmacological ehaviors "to evaluate" the e as needed lorazepam. There e use of this medication at the ed.  ed facility policy titled, cation Use Guidelines",				
	to residents require	bjectively" document		<b>'</b> O		
	The director of nursidevelop and impler to ensure that residunnecessary medicinclude parameters staff. The DON or omonitoring systems	cations, ensure all medications, and educate all relevant designee can develop to ensure ongoing port the findings to the Quality				
	TIME PERIOD FOR (14) days.	R CORRECTION: Fourteen				

6899

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SU IDENTIFICATIO		` '	E CONSTRUCTION		E SURVEY PLETED
				7.1. 20.22.1.10.1			С
		00614		B. WING		12/	08/2016
	PROVIDER OR SUPPLIER  NURSING AND REHA	B CENTER	1717 UNI\		STATE, ZIP CODE IVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIE  / MUST BE PRECEDE  SC IDENTIFYING INF	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21550	MN Rule 4658.1329 Medications; Pharm Subpart 1. Pharma must arrange for th services.	nacy Śerv. acy services. A r	nursing home	21550			1/17/17
	This MN Requirements: Based on observation review, the facility for were given according instructions for 1 of Findings include:	on, interview, an ailed to ensure in ag to manufacture 1 residents (R94)	d document nedications res 4).		Completed		
	R94's Individual Resident Care Plan dated 12/1/16, indicated R94 was at risk for choking and aspiration and was to receive nothing by mouth (NPO). R94's Admission Record face sheet indicated R94 had a malignant neoplasm o the mouth.						
	R94's Dismissal Sudated 12/1/16, indic (difficulty swallowin (percutaneous endoplaced in abdomina nutrition, fluids and into the stomach, be esophagus) tube preceive myrbetriq (roveractive bladder) release (designed tover a extended permorning.	cated R94 had dy g) and had a per oscopic gastrostral wall and stomator for medications to ypassing the mo- laced. Further, a medication for transparent to 25 milligrams (no o release medication of time) by	ysphagia g omy, which is ich to allow o put directly uth and R94 was to eatment of ing) sustained ation in body mouth every				
	A speech therapy (	ST) Plan Of Care	e, dated				

6899

winneso	ta Department of He	aiiri		r			
	IT OF DEFICIENCIES		R/SUPPLIER/CLIA	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFIC	ATION NUMBER:	A. BUILDING:		COMP	LETED
							;
		00614		B. WING			8/2016
NAME OF I	PROVIDER OR SUPPLIER		CTDEET AD	DDECC CITY (	STATE, ZIP CODE		
NAIVIE OF I	PROVIDER OR SUPPLIER			, ,	,		
TALAHI I	NURSING AND REHA	B CENTER			IVE SOUTHEAST		
				OUD, MN 5		_	
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		CEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE	(X5) COMPLETE DATE
21550	Continued From pa	ge 52		21550			
	12/02/16, indicated on command and h noted.						
	During observation listened practical numedications. LPN-medications except stated the medication and could not be crigiven by mouth. LF administered R94's myrbetriq, via peg twould not be able to she was uncertain in During interview 12 stated she spoke well.	urse (LPN)- I A crushed all for THE mylon was "sust ushed, and v PN-D entered medications ube. LPN-A o give R94 m f R94 could s /07/16, at 1:0	D set up R94's I of R94's rbetriq. LPN-D ained released" vas ordered to be I R94's room and c, except then stated she hyrbetriq because swallow the pill.				
	discontinued myrbe had received the m admission, but was administered this m	yrbetriq five to uncertain ho uedication to	times since bw the staff R94.	V			
	During interview 12 director of nursing (have been giving thand administering it stated the nurses swith R94's physician	DON) stated be myrbetriq t via the peg hould have c	I the staff must by crushing it, tube. The DON				
	During a subsequer 9:21 a.m. LPN-D st myrbetriq by crushin peg tube.	ated she had	d given R94				
	A facility policy was medications accord specifications and v	ling to manuf	acture				

Minnesota Department of Health

A Patient Information from the manufacture

STATE FORM 6899 J6VE11 If continuation sheet 53 of 67

IVIIIIIICSC	na Department of the	i i i i i i i i i i i i i i i i i i i	1			
-	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	PLETED
						`
		00614	B. WING			)8/2016
		00014			12/0	J6/2010
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		1717 UNI	VERSITY DR	IVE SOUTHEAST		
TALAHI	NURSING AND REHA	R CENTER	OUD, MN 5			
	OU 11 41 44 FV OTA		1			
(X4) ID PREFIX		TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI		DATE
				DEFICIENCY)		
04550	0 " 15	50	04550			
21550	Continued From pa	ige 53	21550			
	Astellas Pharma US	S, Inc. revised August 2016,				
		"You should take Mybetriq with				
		the tablet whole. Do not crush				
	or chew the tablet".					
	or onow the tablet.					
	SUGGESTED MET	HOD OF CORRECTION:				
		sing and or pharmacist can				
		sponsible for medication				
		outdated medications to				
		use by resident/s, and ensure				
		ded according to manufacture				
		The DON or designee can				
		systems to ensure ongoing				
		oort the findings to the Quality	1			
	Assurance Commit					
	Assurance Commit	ilee.				
	TIME DEDIOD EOE	R CORRECTION: Twenty-one				
		A CONNECTION. TWEITLY-OTIE				
	(21) days.					
21705	MN Rule 4658.1415		21705			1/17/17
	Housekeeping, Ope	eration, & Maintenance				
		air conditioning, and				
		ing home must operate and				
		anical systems to provide				
		fe temperatures, air changes,				
		. Temperatures in all resident				
		ntained according to items A to				
	C:					
		ction of a new physical plant, a				
		maintain a temperature range				
		enheit to 81 degrees				
	Fahrenheit at all tim					
		facilities, a nursing home				
	must maintain a m	inimum temperature of 71				
	degrees Fahrenheit	t during the heating season.				
		he temperatures required by				
		allowed if the variations are				

	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:				LETED
					C	)
		00614	B. WING		12/0	8/2016
NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
TALAHI I	NURSING AND REHA	RCENIER		IVE SOUTHEAST		
(VA) ID	CLIMMA DV CTA	TEMENT OF DEFICIENCIES	OUD, MN 50	PROVIDER'S PLAN OF CORRECTION		(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21705	Continued From pa	ge 54	21705			
	based on documented resident preferences.					
	by:	ent is not met as evidenced				
	Based on observation review, the facility facili	on, interview, and document ailed to provide housekeeping ervices necessary to maintain ratures 2 of 5 resident rooms one or three resident in the facility, which had the 0 residents who used these on 12/08/16, at 12:47 p.m. an of the facility was conducted upervisor (MS) who confirmed is:		Completed		
	dining room, was co	pool. The temperature grees Fahrenheit (F).				
	In R162, the tempe at 70 degrees F.	rature in the room measured				
	In R167 the temper 66 degrees F.	ature in the room measured at				
	findings listed above practice was for fact with concerns with pup in the morning a maintenance staff. I checked resident or temperatures in over	3 p.m. MS confirmed all of the e. MS stated the usual facility illity staff to notify maintenance paper slips, which were picked as needed by the Further, MS stated he had not a common area room er a month because he did not as working on getting around				

	NT OF DEFICIENCIES OF CORRECTION		R/SUPPLIER/CLIA CATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY
				A. BUILDING:			
		00614		B. WING			)8/2016
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TALAHI	NURSING AND REHA	B CENTER		VERSITY DR OUD, MN 50	IVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC <sup>N</sup> REGULATORY OR L		CEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
21705	Continued From pa	ıge 55		21705			
	A policy on facility rebut was not provided Suggested Method facility operations (could work with the policies and proced for the resident room or designee could prooms to determine adequate.	of Correction OF) operation OF) operation administrate dures for whe ms, and ension temperate perform audit	n: The director of ions or designee or to update in to regulate heat ure a process to ures. The DON is of resident				
21800	Time Period for Co  MN St. Statute144. Residents of HC Fa	651 Subd. 4	Patients &	21800			1/17/17
	Subd. 4. Informal residents shall, at a are legal rights for stay at the facility of treatment and main that these are described written statement of responsibilities set case of patients ad as defined in section statement shall also person 16 years old provided in section shall list the names individuals and organd advocacy and legal residential program accommodations second and an accommodation impospeak a language of	ation about rigadmission, be their protection their protection of their protection of their protection and a fit the application of the applicatio	ghts. Patients and a told that there on during their their course of the community and ccompanying ole rights and section. In the idential programs he written e right of a request release as bdivision 2, and the numbers of at provide repatients in ble of for those with dictions their controls of the c				

6899

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMPI	SURVEY LETED
					С	
		00614	B. WING		12/0	8/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TALAHI	NURSING AND REHA	RCENTER	/ERSITY DR OUD, MN 50	IVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21800	Continued From pa	ge 56	21800			
	local health authorit the written statement to patients, resident chosen representate to the administrator person, consistent of Practices Act, and sixulnerable adults.  This MN Requirement by:  Based on interview facility failed to provinctice to 2 of 6 residents.	pection findings of state and ties, and further explanation of nt of rights shall be available ts, their guardians or their ives upon reasonable request or other designated staff with chapter 13, the Data section 626.557, relating to ent is not met as evidenced and document review, the vide the appropriate liability dents (R64 and R91) reviewed and from Medicare services.		Completed		
	Findings include:		O			
	10/28/16, indicated	inimum Data Set (MDS), dated he received physical and while admitted in the facility.				
	Medicare Non-Cove explains a resident' through the QIO or Organization on 11/ services where end discharged from the received notice form Straits Health as the received the form C 10095, which was the services of the servi	I and signed a Notice of erage CMS 10095 (which is right to an immediate appeal Quality Improvement (4/16, identifying his Medicare ling on 11/7/16. R64 was efacility on 11/8/16. R64's in CMS 10095, which identified e QIO. R64 should have CMS 10123, and not the CMS the incorrect form.				
	he received physica	al and occupation therapy he facility. R91 was a current				

6899

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7. BOILDING			)
		00614	B. WING			8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
TALAHI	NURSING AND REHA	R CENTER	/ERSITY DR OUD, MN 5	IVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21800	Continued From pa	ge 57	21800			
	resident at the facil	ity.				
	10095 on 11/22/16, ending on 11/24/16 facility, he also rece on continued stay (financial obligations end). R91 should h 10123, and not the incorrect form.  During interview on business office staf 10095 was form sh issue. BOS stated difference between 10123, and did not was. BOS stated s	signed liability notice form CMS regarding Medicare services. Since R91 remained in the eived the a SNF determination which explains a resident's when Medicare services ave received the form CMS CMS 10095, which was the 12/7/16, at 1:08 p.m. If (BOS) stated the form CMS e had been instructed to she was unaware of any forms CMS 10095 and CMS know who the facility's QIO he "never really looked at ing the liability notices to				
	of nursing (DON) st	12/8/16, at 2:56 p.m. director tated she was unaware of the CMS 10095 and CMS 10123, used for their QIO.		<b>'</b> O		
		website identified the CMS d 10/31/2013, over three years				
	The administrator of review, and/or revise ensure staff are edilability notices to proper Medicare services, are communicated The administrator of	THOD OF CORRECTION: or designee could develop, se policies and procedures to ucated on the appropriate rovide residents at the end of and to ensure resident rights appropriately and acted upon. or designee could educate all a the policies and procedures				

Minnesota Department of Health

-	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BOILDING	•	c	
		00614	B. WING			08/2016
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TALAHI I	NURSING AND REHA	AR CENTER	NIVERSITY DE CLOUD, MN 5	RIVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21800	Continued From pa	age 58	21800			
	and develop a mon ongoing complianc	nitoring systems to ensure e.				
	TIME PERIOD FOI (21) Days	R CORRECTION: Twenty-or	е			
21855	MN St. Statute 144 Residents of HC Fa	e.651 Subd. 15 Patients & ac.Bill of Rights	21855			1/17/17
	residents shall have and privacy as it re personal care prog consultation, exam confidential and sh Privacy shall be res bathing, and other	ment privacy. Patients and e the right to respectfulness lates to their medical and ram. Case discussion, ination, and treatment are all be conducted discreetly. spected during toileting, activities of personal hygiene for patient or resident safety of				
	by: Based on observat review, the facility f privacy was provide	ent is not met as evidenced ion, interview, and document failed to ensure personal ed by staff for 1 of 5 residents ependent upon staff for ring.		Completed		
	Findings include:					
	had dementia and individual Resident	ecord, undated, indicated R9 a neurological disease. The Care Plan dated 12/1/16, ded staff assistance with and grooming.	4			
		12/05/16, at 7:09 p.m. R94 th her sheets pulled down.				

6899

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Minnesota Department of Health

-	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/IDENTIFICATION	SUPPLIER/CLIA TION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				A. BUILDING:			,
		00614		B. WING		12/0	) 8/2016
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TALAHI	NURSING AND REHA	B CENTER		VERSITY DR OUD, MN 50	IVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L		DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21855	Continued From particles of R94 was lying on high gown completely of bare back and buttout product. R94's doon hallway, as staff and Numerous staff we room, but made no cover herself or clooprivacy.  During interview or practical nurse (LP around" and must let LPN-A stated (R94 uncovered for other to be	er left side, with pen in the back ocks with an in reason was completed visitors walk re observed what tempts to asset the door to a 12/05/16, 7:21 N)-A stated Reave pulled off should not have pulled off should not have back side. Reave pulled off back side. Reave pulled off should not have back side. Reave pulled off should not have back side. Reave which had fall her buttocks. In unidentified reation from the stroom. Staff R94, or close honal privacy.  2/08/16, at 9:31 (DON), stated acy and attempt a stated the facing the staff on sted for privacy.	k, exposing her acontinent ely open to the ed past. alking by R94's esist R94 to maintain R94's 0 p.m. licensed 04"fidgets her sheets ave been left 2:55 a.m., R94 por completely 04 wore an llen down and Staff walked by hurse was e cart parked made no er door to 1 a.m. the staff should privacy. It is a staff walked by hurse was e cart parked made no er door to 1 a.m. the staff should privacy. It is a staff walked by hurse was exart parked made no er door to 1 a.m. the staff should privacy. It is a staff walked by hurse was exart parked made no er door to 1 a.m. the staff should privacy. It is a staff walked by hurse was exart parked made no er door to 1 a.m. the staff should privacy. It is a staff walked by a staff walked b	21855			

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					(	
		00614	b. WING		12/0	8/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TALAHI I	NURSING AND REHA	R CENTER	OUD, MN 50	IVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21855	Continued From pa	ge 60	21855			
	designee could edu the policies and pro	rector of Nursing Services or locate all appropriate staff on locedures. The Director of r designee could develop to ensure ongoing				
	TIME PERIOD FOR Twenty-One (21) da					
21942	MN St. Statute 144. Resident and Fami	A.10 Subd. 8b Establish ly Councils	21942			1/17/17
	boarding care home advisory council an fewer than three pe participating. If one function, the nursin home shall docume council or councils year. This subdivisi	council. Each nursing home or e shall establish a resident d a family council, unless resons express an interest in or both councils do not g home or boarding care ent its attempts to establish the at least once each calendar on does not alter the rights of ies provided by section n 27.				
	by: Based on interview facility failed to esta	and document review, the ablish a family council for the had the potential to affect all esided in the facility.		Completed		
	Findings include:					
	team indicated the	ents provided to the survey facility attempted to establish letter invited people to a				

Minnesota Department of Health STATE FORM

Minneso	<u>ita Department of He</u>	alth					
	IT OF DEFICIENCIES OF CORRECTION				E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00614		B. WING	·····	12/0	) 8/2016
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TALAHI	NURSING AND REHA	B CENTER		/ERSITY DR OUD, MN 50	IVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIEI / MUST BE PRECEDEI SC IDENTIFYING INFO	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21942	Continued From pa	ge 61		21942			
	"Family Interest Grogive family and fried affect their loved or indicate a meeting with agenda items.  In an interview on 1 facility administrato was discussed on management in ear administrator also sat the facility discus holidays coming up after the holiday se stated we needed twe are comfortable	pup" whose purponds a voice in declars" The letter, date of May 13, 2 2/7/16 at 4:04 p. r said the the familiar to the facility November. The said the interdisciples and decided to try to get a coason. The admir to get Talahi to a per talahi talah	cisions that undated, 2015, along m., the nily council ity's he plinary team d, with the ouncil going histrator blace where				
	we are comfortable were best invested compliance" and wi make an attempt to administrator acknow council since May of denied putting the ethe back burner, but extenuating circums administrator felt the establish the council "It was not on the compared to the council of the co	to bring the facilit until after the host re-establish the owledged no move of 2015. The admentablishment of the insisted there we stances this past ere was a better il after the holida	ty "up to blidays to council. The rement on the ninistrator, the council on rere a lot of year. The chances to ys, and stated				
	A review of a facility Weekly Admin (adn operating officer) C the words "family co Admissions/Market provided no further establishment of a	ninistration)/COC all, dated 11/7/20 ouncil" under the ing section. The documentation re	) (chief ) 16, indicated facility				
	SUGGESTED MET facility could send a members, and/or ta see if a family coun	letter out to all fall to all fall to all fall to all family me	amily embers to				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
			A. BOILDING.			,
		00614	B. WING		12/0	)8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TALABI	NURSING AND REHA	P CENTED 1717 UNIV	ERSITY DR	IVE SOUTHEAST		
IALAIII	NUNSING AND NENA	SAINT CL	OUD, MN 50	6304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21942	Continued From page 62		21942			
	TIME PERIOD OF days	CORRECTION: Twenty (21)				
21980	MN St. Statute 626 Maltreatment of Vu	.557 Subd. 3 Reporting - Inerable Adults	21980			1/17/17
	reporter who has revulnerable adult is lor who has knowled has sustained a phreasonably explained information to the condividual is a vulnerable individual is a dreporter is not required maltreatment of the to admission, unless (1) the individual was another facility and believe the vulnerable previous facility; or (2) the reporter k that the individual is in section 626.5572 (b) A person not provisions of this sas described above (c) Nothing in this known or suspected knows or has reason been made to the condition of the condi	as admitted to the facility from the reporter has reason to be adult was maltreated in the mows or has reason to believe a vulnerable adult as defined 2, subdivision 21, clause (4). required to report under the ection may voluntarily report				

6899

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. DOILDING.	·		<u>}</u>
	00614	B. WING	<del></del>		8/2016
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
TALAHI NURSING AND REHA	AR CENTER	/ERSITY DR OUD, MN 5	IIVE SOUTHEAST 6304		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
(5), occurred must subdivision. If the time believes that a agency will determ the reported error with the criteria under such that a the criteria under such that a the criteria under such that the criteria under such t	sion 17, paragraph (c), clause make a report under this reporter or a facility, at any an investigation by a lead ine or should determine that was not neglect according to section 626.5572, subdivision clause (5), the reporter or e to the common entry point or agency information explaining ets the criteria under section sion 17, paragraph (c), clause ncy shall consider this making an initial disposition of abdivision 9c.  The time to the time to the time to the sure allegations of abuse and the origin were immediately ministrator and/or state agency roughly investigated for 2 of 5 dr. R33) whose allegations of the time to	21980	Completed		

Minnesota Department of Health

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Minnesota Department of Health

-	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00614	B. WING	<del></del>	12/0	) 8/2016
_	PROVIDER OR SUPPLIER	R CENTER 1717 UN		STATE, ZIP CODE RIVE SOUTHEAST 6304	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
21980	further indicated RS and when asked if and nodded. There administrator and s notified of the injury thorough investigat the possible cause  During interview on administrator was used to be a smiled after being a was probably why to the administrator to cognitively impaired reported immediated then investigated.  R33's quarterly MD she was severely coare plan dated 03/impaired thought proceed impaired thought proceed impaired thought proceed and the difficulty verbalizing.  A Incident Report of nursing assistant (Nourse (RN)-B that a allegedly took place 11/12/16, with an allimmediately susper rough while grabbing morning cares on 1 and two bruises we on the top of her arcm; and one on the	27 had no complaints of pain she bumped it, R97 smiled was no indication the tate agency were immediately of known origin, nor was a ion completed to determine of the injury.  12/07/16, at 11:00 a.m. the mable to recall the incident. R97 nodded her head and asked if she bumped it, this he incident was not reported. Hen stated if the resident is at the report should have been bely reported to her, SA and S dated 09/06/16, indicated ognitively impaired. R33's (02/15, indicated she had rocesses and cognitive status imer's disease, and had meeds.  ated 11/15/16, indicated NA)-H reported to registered a possible abuse incident and ded NA-H reported she was noded. NA-H reported she was not reported.		DEFICIENCY		
	bruises located on	2 cm. There were also R33's right forearm, 4.5 cm, and the one on the				

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STATEMEN	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00614			12/0	
NAME 05.		00614			12/0	8/2016
	PROVIDER OR SUPPLIER	1717 UNI\		STATE, ZIP CODE IIVE SOUTHEAST		
TALAHI	NURSING AND REHA	R CENTER	OUD, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21980	Continued From pa	ge 65	21980			
	indicated the incide agency on 11/15/16 occurred. There was administrator and sometified of the incide During interview 12 facility administrato have been" immedi SA on 11/12/16, but 11/15/16 to report the stated once she was	tate agency was immediately				
	Review of the facilit Abuse Policy and P indicated all allegat abuse must be repoimmediately. The p is unexplainable, or reported or witness neglect a report muthe Minnesota Depicall the administration	ry Vulnerable Adult Protection, Procedure dated, 11/28/16, ions and/or suspicious of orted to the administrator policy further indicated if injury allegation of abuse is ed, if there is caregiver ust immediately be reported to partment of Health (MDH) and per immediately. The policy ternal, facility investigation of				
	The administrator, education to facility of maltreatment to administrator or desafety and well beir and education to fa neglect and injury cadministrator or desmonitoring for comp	THOD OF CORRECTION: or designee, could provide staff on reporting allegations the state agency. The signee could ensure residents or by providing supervision cility staff on abuse and of unknown origin. The signee could provide could provide of could provide monitoring for				

6899

Minnesota Department of Health STATE FORM

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE : COMPL	SURVEY LETED
		00614			12/0	) 8/2016
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 12,00	5,2010
TALAHI	NURSING AND REHA	RCENTER	/ERSITY DR OUD, MN 5	IVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21980	Continued From pa	ge 66	21980			
	TIME PERIOD OF	CORRECTION: Ten (10) days				
	TIME I EITIOD OF	OOTHILOTION. Tell (10) days				
		17				

6899

Minnesota Department of Health STATE FORM

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: J6VE

## MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

	PARI	I - IO BE COM	PLETED BY I	HE STATI	E SURVEY AGENCY	Fi	acility ID: 00614	
MEDICARE/MEDICAID PROVIDER     (L1) 245438	NO.		ME AND ADDRESS OF FACILITY ALAHI NURSING AND REHAB CENTER			4. TYPE OF ACTION:  1. Initial	7 (L8)	
2.STATE VENDOR OR MEDICAID NO.		(L4) 1717 UNIVE	RSITY DRIVE S	OUTHEAS	Γ	3. Termination	4. CHOW	
(L2) <b>885463000</b>		(L5) SAINT CLO	UD, MN		(L6) <b>56304</b>	5. Validation 7. On-Site Visit	6. Complaint 9. Other	
5. EFFECTIVE DATE CHANGE OF OW	/NERSHIP	7. PROVIDER/SUI	PPLIER CATEGOR	Y	<u>02</u> (L7)	0 F H C 46 C	1	
(L9) <b>06/01/2013</b>		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Survey After Cor	тріаінt 	
6. DATE OF SURVEY <b>02/0</b>	<b>7/2017</b> (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FIGGAL WEAR ENDING	DATE (125)	
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	FISCAL YEAR ENDING	DATE: (L35)	
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31		
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED AS	:				
From (a):		X A. In Complian	nce With		And/Or Approved Waivers Of The	Following Requirements:	<u> </u>	
To (b):		Program Re			2. Technical Personnel	_ 6. Scope of Servi	ces Limit	
		Compliance	Based On:		3. 24 Hour RN	7. Medical Direct	tor	
12 Tatal Facility Dada	<b>77</b> (110)	1. A	Acceptable POC		4. 7-Day RN (Rural SNF)	8. Patient Room S	lize	
12.Total Facility Beds	77 (L18)				5. Life Safety Code	9. Beds/Room		
13.Total Certified Beds	<b>77</b> (L17)		pliance with Program and/or Applied Wais		* 0 1 4 4	(L12)		
14 LTG CERTIFIED DED DREAMDONS	T	Requirements	and/of Applied war	vers.	* Code: A*  15. FACILITY MEETS	(E12)		
14. LTC CERTIFIED BED BREAKDOW!		IOD	WD.			(I 15)		
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
77								
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMAR	KS (IF APPLICABLE S	HOW LTC CANCELI	LATION DATE):					
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY AP	PPROVAL	Date:	
Michelle Thomps	son, HFE NE	II	02/07/2017	(L19)	Kate JohnsTon, Program Specialist 03/16/2017 (L20)			
	PART II - TO	BE COMPLETE	D BY HCFA R	EGIONAL	OFFICE OR SINGLE STAT	TE AGENCY		
19. DETERMINATION OF ELIGIBILIT	Y		MPLIANCE WITH O	CIVIL	<ul> <li>21. 1. Statement of Financial Solvency (HCFA-2572)</li> <li>2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)</li> <li>3. Both of the Above :</li> </ul>			
_X 1. Facility is Eligible to Pa	rticipate	Rioi	argher.					
2. Facility is not Eligible	<i>a.</i> 21)							
	(L21)							
22. ORIGINAL DATE	23. LTC AGREEMI	ENT 2	24. LTC AGREEMI	ENT	26. TERMINATION ACTION:	(I	2.30)	
OF PARTICIPATION	BEGINNING I	DATE	ENDING DAT	E	VOLUNTARY 00	<u>INVOLUNT</u>	ARY	
02/01/1987					01-Merger, Closure	05-Fail to Me	eet Health/Safety	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburseme	ent 06-Fail to Me	eet Agreement	
25. LTC EXTENSION DATE:	27. ALTERNATIVI	E SANCTIONS			03-Risk of Involuntary Termination	OTHER		
	A. Suspension of				04-Other Reason for Withdrawal		Status Change	
	1		(L44)			00-Active		
(L27)	B. Rescind Sus	pension Date:						
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/C	CARRIER NO.		30. REMARKS			
		03001						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION (	OF APPROVAL DA	TE	Posted 03/24/2017 Co.			
	32	01/23/2017			1 00000 00/2 1/2017 00.			
	(L32)	,,,		(L33)	DETERMINATION APPRO	VAL		



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245438 March 16, 2017

Ms. Marlene Smith, Administrator Talahi Nursing & Rehabilitation 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 January 17, 2017 the above facility is certified for or recommended for:

77 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Talahi Nursing And Rehab Center March 16, 2017 Page 2

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered March 14, 2017

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

RE: Project Number S5438028

Dear Ms. Smith:

On December 23, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 8, 2016 that included an investigation of complaint number H5438047.

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 February 7, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 8, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 17, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 8, 2016, effective January 17, 2017 and therefore remedies outlined in our letter to you dated December 23, 2016, will not be imposed.

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

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.

Talahi Nursing & Rehabilitation Center March 14, 2017 Page 2

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

### POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT			
IDENTIFICATION NUMBER	A. Building					
245438 <sub>Y1</sub>	B. Wing	Y2	2/7/2017	Y3		
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE				
TALAHI NURSING AND REHAB CENTER		1717 UNIVERSITY DRIVE SOUTHEAST				
		SAINT CLOUD, MN 56304				

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

ITE	М		DATE	ITEM			DATE	ITEM			DATE
Y4			Y5	Y4			Y5	Y4			Y5
ID Prefix	F0164		Correction	ID Prefix	F0167		Correction	ID Prefix	F0225		Correction
Reg.#	483.10(h)(1)(3)(i); 483.70(i)(2)		Completed	Reg. #	483.10(	g)(10)(i)(11)	Completed	Reg.#	483.12(a)(3)(4)(c)(1)	)-(4)	Completed
LSC			01/02/2017	LSC			01/17/2017	LSC			01/17/2017
ID Prefix	F0226		Correction	ID Prefix	F0250		Correction	ID Prefix	F0257		Correction
Reg. #	483.12(b)(1)-(3), 483.95(c)(1)-(3)		Completed	Reg. #	483.40(	d)	Completed	Reg.#	483.10(i)(6)		Completed
LSC			01/17/2017	LSC			01/17/2017	LSC			01/17/2017
ID Prefix	F0280		Correction	ID Prefix	F0281		Correction	ID Prefix	F0282		Correction
Reg. #	483.10(c)(2)(i-ii,iv, (3),483.21(b)(2)	v)	Completed	Reg. #	483.21(	b)(3)(i)	Completed	Reg.#	483.21(b)(3)(ii)		Completed
LSC			01/17/2017	LSC			01/17/2017	LSC			01/17/2017
ID Prefix	F0312		Correction	ID Prefix	F0314		Correction	ID Prefix	F0315		Correction
Reg.#	483.24(a)(2)		Completed	Reg. #	483.25(	b)(1)	Completed	Reg.#	483.25(e)(1)-(3)		Completed
LSC			01/17/2017	LSC			01/17/2017	LSC			01/17/2017
ID Prefix	F0323		Correction	ID Prefix	F0329		Correction	ID Prefix	F0353		Correction
Reg.#	483.25(d)(1)(2)(n)	(1)-(3)	Completed	Reg. #	483.45(	d)	Completed	Reg.#	483.35(a)(1)-(4)		Completed
LSC			01/17/2017	LSC			01/17/2017	LSC			01/17/2017
REVIEWE STATE AG		REVIEWE (INITIALS		DATE 03/14/	2017	SIGNATURE O		28598		DATE 02/07	7/2017
REVIEWE CMS RO	D BY	REVIEWE (INITIALS		DATE		TITLE				DATE	

## **POST-CERTIFICATION REVISIT REPORT**

					<b></b> : \( \)		<i>,</i> , , , , , , , , , , , , , , , , , ,	• • • • • •					
	R / SUPPLIE CATION NUM			MULTIPLE CONS A. Building B. Wing	TRUCTION							DATE O 2/7/201	F REVISIT
NAME OF	FACILITY NURSING A	.ND F	11					1717 UNI	ADDRESS, CIT VERSITY DRIV OUD, MN 5630	E SOUTHEAS			, A3
program, corrected provision	to show the	ose d te su d the	eficiencie: ch correc	s previously repo tive action was a	rted on the ccomplished	CMS-25 d. Each	667, Statem deficiency	nent of De should be	ficiencies and fully identifie	Plan of Cored using either	ent Amendments rection, that have er the regulation of of each requireme	r LSC	
ITE	VI			DATE	ITEM				DATE	ITEM			DATE
Y4				Y5	Y4				Y5	Y4			Y5
ID Prefix	F0365			Correction	ID Prefix	F0371			Correction	ID Prefix	F0387		Correction
Reg. #	483.60(d)(3	)		Completed	Reg. #	483.60(	i)(1)-(3)	(	Completed	Reg.#	483.30(c)(1)(2)		Completed
LSC				01/17/2017	LSC				01/17/2017	LSC			01/17/2017
ID Prefix	F0425			Correction	ID Prefix	F0431			Correction	ID Prefix	F0441		Correction
Reg.#	483.45(a)(b	)(1)		Completed	Reg. #	483.45(	b)(2)(3)(g)(h)	)	Completed	Reg. #	483.80(a)(1)(2)(4)(	e)(f)	Completed
LSC				01/17/2017	LSC				01/17/2017	LSC			01/17/2017
ID Prefix	F0501			Correction									
Reg. #	483.70(h)(1	)(2)		Completed									
LSC				01/17/2017									
					†								
REVIEWE	D BY		REVIEW	ED BY	DATE		SIGNATUR	RE OF SUR	VEYOR			DATE	
STATE AG	ENCY		(INITIAL:	s) BF/KJ	03/14/	2017			2	28598		02/07	/2017
REVIEWE CMS RO	D BY		REVIEW (INITIAL:		DATE		TITLE					DATE	
FOLLOWU 12/8/2016	JP TO SURV	EY C	OMPLETE	OON					DEFICIENCIES MS-2567) SEN			YES	в 🔲 но



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered March 14, 2017

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

Re: Reinspection Results - Project Number S5438028

Dear Ms. Smith:

On February 7, 2017 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on February 7, 2017, that included an investigation of complaint number H5438047. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

### STATE FORM: REVISIT REPORT

IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building		DATE OF REVISIT	
00614 <sub>Y1</sub>	B. Wing	Y2	2/1/2017	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
TALAHI NURSING AND REHAB C	ENTER	1717 UNIVERSITY DRIVE SOUTHEAST		
		SAINT CLOUD, MN 56304		

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

ITE	М		DATE	ITEM			DATE	ITEM			DATE
Y4			Y5	Y4			Y5	Y4			Y5
ID Prefix	20565		Correction	ID Prefix	20570		Correction	ID Prefix	20800		Correction
Reg.#	MN Rule 4658.04 Subp. 3	05	Completed	Reg. #	MN Rul Subp. 4	e 4658.0405	Completed	Reg. #	MN Rule 4658.051 Subp. 1	10	Completed
LSC			02/07/2017	LSC			02/07/2017	LSC			02/07/2017
ID Prefix	20830		Correction	ID Prefix	20835		Correction	ID Prefix	20900		Correction
Reg.#	MN Rule 4658.05 Subp. 1	20	Completed	Reg. #	MN Rul Subp. 2	e 4658.0520	Completed	Reg. #	MN Rule 4658.052 Subp. 3	25	Completed
LSC			02/07/2017	LSC			02/07/2017	LSC			02/07/2017
ID Prefix	20910		Correction	ID Prefix	21235		Correction	ID Prefix	21290		Correction
Reg.#	MN Rule 4658.05 Subp. 5 A.B	25	Completed	Reg. #	MN Rul Subp. 2	e 4658.0700	Completed	Reg. #	MN Rule 4658.071 Subp. 3 A	10	Completed
LSC			02/07/2017	LSC			02/07/2017	LSC			02/07/2017
ID Prefix	21390		Correction	ID Prefix	21475		Correction	ID Prefix	21540		Correction
Reg.#	MN Rule 4658.08 Subp. 4 A-I	00	Completed	Reg. #	MN Rul Subp. 1	e 4658.1005	Completed	Reg. #	MN Rule 4658.131 Subp. 2	15	Completed
LSC	· · · · · · · · · · · · · · · · · · ·		02/07/2017	LSC			02/07/2017	LSC			02/07/2017
ID Prefix	21550		Correction	ID Prefix	21705		Correction	ID Prefix	21800		Correction
Reg.#	MN Rule 4658.13 Subp. 1	25	Completed	Reg. #	MN Rul Subp. 6	e 4658.1415	Completed	Reg.#	MN St. Statute144 Subd. 4	.651	Completed
LSC			02/07/2017	LSC			02/07/2017	LSC			02/07/2017
						Т					
STATE AG		(INITIALS		03/14/	2017	SIGNATURE OF		8598		02/0	7/2017
REVIEWE CMS RO	D BY	REVIEWE (INITIALS		DATE		TITLE				DATE	

Page 1 of 2 EVENT ID: J6VE12

#### STATE FORM: REVISIT REPORT DATE OF REVISIT PROVIDER / SUPPLIER / CLIA / MULTIPLE CONSTRUCTION **IDENTIFICATION NUMBER** A. Building 2/7/2017 B. Wing 00614 Υ3 NAME OF FACILITY STREET ADDRESS, CITY, STATE, ZIP CODE TALAHI NURSING AND REHAB CENTER 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304 This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form). ITEM DATE ITEM DATE ITEM DATE Y4 Y5 Y4 Y5 Y4 Y5 **ID Prefix** 21855 Correction **ID Prefix** 21942 Correction **ID Prefix** 21980 Correction MN St. Statute 144.651 MN St. Statute 144A.10 MN St. Statute 626.557 Reg. # Completed Reg. # Completed Completed Reg. # Subd. 15 Subd. 8b Subd. 3 02/07/2017 02/07/2017 02/07/2017 LSC LSC LSC **REVIEWED BY** DATE DATE **REVIEWED BY** SIGNATURE OF SURVEYOR STATE AGENCY (INITIALS) BF/KJ 03/14/2017 28598 02/07/2017 DATE TITLE DATE **REVIEWED BY REVIEWED BY** CMS RO (INITIALS) CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF FOLLOWUP TO SURVEY COMPLETED ON UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? 12/8/2016 YES NO Page 2 of 2 EVENT ID: J6VE12

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: J6VE

## MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

		PART	I - TO BE COM	PLETED BY T	HE STATI	E SURVEY AC	GENCY	F	acility ID: 00614
MEDICARE/MEDICAID PRO     (L1)			3. NAME AND ADI (L3) TALAHI NUI (L4) 1717 UNIVEI (L5) SAINT CLOU	RSING AND REI RSITY DRIVE SO	HAB CENT	Γ	56304	4. TYPE OF ACTION:  1. Initial  3. Termination  5. Validation	2 (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE (L9) <b>06/01/2013</b>			7. PROVIDER/SUP	05 HHA	09 ESRD	<u>02</u> (L7	22 CLIA	7. On-Site Visit  8. Full Survey After Con	9. Other mplaint
		(L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING	DATE: (L35)
(L37) (	77 ( 77 ( KDOWN 19 SNF 77 L38)	(L17) 19 SNF (L39)	X B. Not in Comp Requirements a ICF (L42)	nce With quirements Based On: cceptable POC pliance with Program and/or Applied Waiv  IID  (L43)		2. Tec 3. 241 4. 7-D	hnical Personnel Hour RN Pay RN (Rural SNF) Pasfety Code B* MEETS	Following Requirements:  6. Scope of Serviction   7. Medical Direction   8. Patient Room Struction   9. Beds/Room   (L12)	tor
STATE SURVEY AGENCY     SURVEYOR SIGNATURE	REMARKS (IF APPL	ICABLE S	SHOW LTC CANCELL  Date :	ATION DATE):		18. STATE SUR	RVEY AGENCY AP	PROVAL	Date:
Michelle Tho	mpson, HFI	E NE	II (	01/06/2017	(L19)	Kate Jo	hnsTon, Pr	ogram Specialis	t 01/23/2017 (L20)
	PART	II - TO	BE COMPLETEI	D BY HCFA RE	EGIONAL	OFFICE OR	SINGLE STAT	E AGENCY	
19. DETERMINATION OF ELIC  _X 1. Facility is Eligi  2. Facility is not	ble to Participate	(L21)		PLIANCE WITH C	IVIL	2.		ial Solvency (HCFA-2572) interest Disclosure Stmt (HCFA	-1513)
22. ORIGINAL DATE  OF PARTICIPATION  02/01/1987  (L24)		AGREEMI GINNING I		4. LTC AGREEME ENDING DATE (L25)		VOLUNTARY 01-Merger, Clos		INVOLUNT. 05-Fail to Me	ARY eet Health/Safety eet Agreement
25. LTC EXTENSION DATE:	27. ALTI A. S	ERNATIVI uspension of	E SANCTIONS of Admissions: pension Date:	(L44)		03-Risk of Involu 04-Other Reason	intary Termination for Withdrawal	OTHER 07-Provider S 00-Active	Status Change
				(L45)					
28. TERMINATION DATE:	(L28)	29	. INTERMEDIARY/C	ARRIER NO.	(L31)	30. REMARKS			
31. RO RECEIPT OF CMS-1539		32	. DETERMINATION C	OF APPROVAL DAT	ΓE	Posted 01	/23/2017 Co.		
	(L32)				(L33)	DETERMIN	ATION APPRO	VAI.	



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered December 23, 2016

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

RE: Project Number S5438028, H5438046, and H5438047

Dear Ms. Smith:

On December 8, 2016, 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 December 8, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5438047 that was substantiated at F353.

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 attached CMS-2567 whereby significant corrections are required. A copy of the Statement of Deficiencies (CMS-2567 and/or Form A) is enclosed. In addition, at the time of the December 8, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5438046 that was found to be unsubstantiated.

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

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

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

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

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

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<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 a "F" tag), i.e., the plan of correction should be directed to:

Brenda Fischer, Unit Supervisor
St. Cloud A Survey Team
Licensing & Certification
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7338

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 January 17, 2017, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

The Department of Health is also recommending to the CMS Region V Office that if your facility has not

achieved substantial compliance by January 17, 2017 the following remedy will be imposed:

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

In addition, Department of Health is also recommending to the CMS Region V Office the imposition of the following remedies:

- Discretionary Denial of Payment for New Medicare and Medicaid Admissions effective February 8, 2016.
- Federal Civil Money Penalty

### 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 March 8, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 8, 2017 (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.

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

PRINTED: 01/26/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY IPLETED
		245438	B. WING				C <b>08/2016</b>
	PROVIDER OR SUPPLIER	B CENTER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 717 UNIVERSITY DRIVE SOUTHEAST 6AINT CLOUD, MN 56304	<u> </u> 12/	00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 164 SS=D	was completed by some periodical treatment, communications, per large and the large periodical treatment, communications, per large per	rs  /16, a recertification survey surveyors from the Minnesota lth (MDH). Talahi Nursing & found to not be in compliance at 42 CFR Part 483, subpart Long Term Care Facilities.  otance. Because you are rour signature is not required a first page of the CMS-2567 ic submission of the POC will tion of compliance. Upon table electronic POC, an aur facility may be conducted to antial compliance with the en attained in accordance with the stigation of complaint appleted and substantiated with the F353 during the survey. An applaint H5438046 was and to be unsubstantiated.  I83.70(i)(2) PERSONAL ENTIALITY OF RECORDS  acy includes accommodations, written and telephone ersonal care, visits, and and resident groups, but this		0000	DEFICIENCY)		1/17/17
	does not require the room for each resident he confidential personal	e facility to provide a private lent. nas a right to secure and al and medical records.					
I AROBATORY	/ DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITI F		(X6) DATE

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

01/04/2017

Electronically Signed

01/04/201

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.

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

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		PLETED
		245438	B. WING			12/0	) 08/2016
	PROVIDER OR SUPPLIER	B CENTER		17	REET ADDRESS, CITY, STATE, ZIP CODE 17 UNIVERSITY DRIVE SOUTHEAST AINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 164	of personal and me provided at §483.70(i)(2) or oth laws.  §483.70 (i) Medical records. (2) The facility must information contain regardless of the forecords, except who will be contained and the presentative where the contained are presentative, as performed and the contained are provided and the contained are prov	at the right to refuse the release edical records except as the rapplicable federal or state are applicable federal or state at the edin the resident's records, form or storage method of the en release is-  or their resident re permitted by applicable law;  or their resident re permitted by applicable law;  or their resident re permitted by and in compliance of;  the activities, reporting of abuse, in activities, reporting of abuse, in colonic, health oversight and administrative proceedings, the activities, or to coroners, and to avert the ealth or safety as permitted on the edith or safety as permitted on the edith of t	F 1	64	F000: Preparation and/or executio this report of correction does not		
		ed by staff for 1 of 5 residents bendent upon staff for activities			constitute admission or agreement provider of the truth of the facts set in the statement of deficiencies req by the provisions of the federal and law.	forth uired	

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED
		245438	B. WING			12/0	) 0 <b>8/2016</b>
NAME OF I	PROVIDER OR SUPPLIER		ı	S	TREET ADDRESS, CITY, STATE, ZIP CODE		30,2010
				17	717 UNIVERSITY DRIVE SOUTHEAST		
TALAHII	NURSING AND REHA	B CENTER		S	AINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 164	Continued From pa	ge 2	F 1	64			
	R94's Admission Record, undated, indicated F had dementia and a neurological disease. The				F164- Personal Privacy of Records		
		Care Plan dated 12/1/16, ed staff assistance with			It is the policy of Talahi Nursing and Rehab Center provide personal pri its residents. The policy has been		
		12/05/16, at 7:09 p.m. R94			reviewed, and is accurate.		
	was lying in bed wit	h her sheets pulled down. er left side, with her hospital			R94 has been relocated to room 17 which is located in a low traffic area		
	gown completely or	pen in the back, exposing her bocks with an incontinent			close to the nurse's station.		
		was completely open to the			Staff have been re-educated on the	e policy	
	Numerous staff wer	d visitors walked past. re observed walking by R94's			to assure privacy for all residents a times. See Exhibit 164A.	t all	
	cover herself or clos	attempts to assist R94 to se the door to maintain R94's			Random audits will be completed the		
	privacy.	10/05/10 7:00 a as lissand			times per week for three weeks to privacy is protected. IDT/QAPI will		
		12/05/16, 7:20 p.m. licensed N)-A stated R94 "fidgets			evaluate outcome of these audits a completion of three weeks and det		
	around" and must h	nave pulled off her sheets.  should not have been left			appropriate action to follow. See Ex		
					DON/designee is responsible		
	was lying in bed, wi	12/06/16, at 7:55 a.m., R94 th the room door completely					
	incontinent product	back side. R94 wore an which had fallen down and					
	R94's room, and an	her buttocks. Staff walked by unidentified nurse was					
	just outside of R94'	cation from the cart parked s room. Staff made no					
	attempts to cover R ensure R94's perso	194, or close her door to nal privacy.					
	director of nursing (	/08/16, at 9:31 a.m. the DON), stated staff should acy and attempted to keep R94					

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION  NG			E SURVEY PLETED
		245438	B. WING				08/ <b>2016</b>
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE 1717 UNIVERSITY DRIVE SOU SAINT CLOUD, MN 56304			33/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIEI	CTION SHOULD O THE APPROPE	BE	(X5) COMPLETION DATE
F 164	covered. The DON working on educatir	ge 3 stated the facility will be ng the staff on privacy. sted for privacy and was not	F 1	54			
F 167 SS=C	( , , , , , , , , , , , , , , , , , , ,	RIGHT TO SURVEY LY ACCESSIBLE	F 1	57			1/17/17
	(g)(10) The residen	t has the right to-					
	of the facility condu	sults of the most recent survey cted by Federal or State plan of correction in effect with y; and					
	(g)(11) The facility r	nust					
	and family member	eadily accessible to residents, s and legal representatives of ts of the most recent survey of					
	certifications, and c respecting the facili years, and any plan	h respect to any surveys, omplaint investigations made ty during the 3 preceding of correction in effect with y, available for any individual uest; and					
		ne availability of such reports in that are prominent and ublic.					
	information about c	I not make available identifying omplainants or residents.  NT is not met as evidenced					
		ion, interview and document		F167-Servey Results			

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

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION NG		E SURVEY PLETED
		245438	B. WING			08/ <b>2016</b>
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF		30,2010
TALAHI	NURSING AND REHA	B CENTER		1717 UNIVERSITY DRIVE SOUTH SAINT CLOUD, MN 56304	EAST	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 167	recent State agency to review. This had residents, visitors at this information.  Findings include:  During the initial to 11:55 a.m., a blue-[Minnesota] Dept [I Results" was found The survey results 12/16/14 (nearly twadditional surveys review.  When interviewed health unit coording in the binder were completed survey, toured the building additional survey receptionist (R)-A sused to house the was typically kept at When interviewed administrator state house the most recand the survey rescurrent adding, "The During subsequent p.m. the administrators at the survey rescurrent adding, "The During subsequent p.m. the administrators at the survey rescurrent adding, "The During subsequent p.m. the administrators at the survey rescurrent adding, "The During subsequent p.m. the administrators at the survey rescurrent adding, "The During subsequent p.m. the administrators at the survey rescurrent adding, "The During subsequent p.m. the administrators at the survey rescurrent adding, "The During subsequent p.m. the administrators at the survey rescurrent adding, "The During subsequent p.m. the administrators at the survey rescurrent adding, "The During subsequent p.m. the administrators at the survey rescurrent adding, "The During subsequent p.m. the administrators at the survey rescurrent adding, "The During subsequent p.m. the administrators at the survey rescurrent adding, "The During subsequent p.m. the administrators at the survey rescurrent adding, "The During subsequent p.m. the administrators at the survey rescurrent adding," The During subsequent p.m. the administrators at the survey rescurrent adding, "The During subsequent p.m. the administrators at the survey rescurrent adding," The During subsequent p.m. the administrators at the survey rescurrent adding the survey rescurrent addi	failed to ensure the most by survey results were available of potential to affect all 70 and staff who wished to review and staff who wished to review are colored binder labeled, "MN Department] of Health Survey of on the West nursing station. Contained inside were dated, to years prior). There was not identified in the binder to contained in the binder to and were unable to locate any esults.  12/5/16, at 12:29 p.m. stated the blue binder was most recent survey results and	F 1	Talahi Nursing and Rehabit post the results of the moof the facility in a readily a for residents, family mem representatives of resider.  The most current survey is reception desk in the fron receptionist is responsible location on a daily basis within the most current survey.  The receptionist maintains audit check off which combook is located on the reception to the front lobby. The Admin confirms accurate placem maintenance of the calent accurate placement of the QAPI will review these auregularly held meetings and determine an appropriate ongoing audits.  A directed in-service was the Administrator by the Fof Operation on compliant adherence to ensure the issurvey results are availab.  The administrator is responsed to the results are available.	st recent survey accessible place bers and legal nts.  s located on the t lobby, and the e to assure its when she is here. ediately when  s a calendar firms the survey ception desk in nistrator and dar check for e survey book.  dits at its and will schedule for conducted by Regional Director ce and most recent le at all times.	

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245438	B. WING				08/ <b>2016</b>
	PROVIDER OR SUPPLIER			S 1	TREET ADDRESS, CITY, STATE, ZIP CODE 717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304	12/0	00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	Х	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225 SS=D	(a) The facility mus		F 2	225			1/17/17
	who- (i) Have been found	d guilty of abuse, neglect, propriation of property, or					
	nurse aide registry	ing entered into the State concerning abuse, neglect, atment of residents or their property; or					
	or her professional body as a result of	nary action in effect against his license by a state licensure a finding of abuse, neglect, atment of residents or resident property.					
	licensing authorities actions by a court of	eate nurse aide registry or so any knowledge it has of of law against an employee, the unfitness for service as a facility staff.					
		allegations of abuse, neglect, treatment, the facility must:					
	abuse, neglect, exp including injuries of misappropriation of reported immediate after the allegation cause the allegatio	alleged violations involving ploitation or mistreatment, in unknown source and it resident property, are ply, but not later than 2 hours is made, if the events that in involve abuse or result in y, or not later than 24 hours if					

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION  NG	COM	E SURVEY IPLETED
		245438	B. WING			C <b>08/2016</b>
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP COE 1717 UNIVERSITY DRIVE SOUTHEAS SAINT CLOUD, MN 56304	DE .	36/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ( (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 225	abuse and do not reconstruction the administrator of officials (including the adult protective serior jurisdiction in lost accordance with Staprocedures.  (2) Have evidence thoroughly investig (3) Prevent further exploitation, or mist investigation is in positive to the administrator or his representative and with State law, included Agency, within 5 wifthe alleged violat corrective action matches the administrator of the alleged violat corrective action matches the administrator of the alleged violat corrective action matches the alleged violate to the administrator of unknown reported to the administrator of the alleged violation of the administrator of the adm	ise the allegation do not involve esult in serious bodily injury, to find facility and to other to the State Survey Agency and vices where state law provides ing-term care facilities) in tate law through established that all alleged violations are ated.  In potential abuse, neglect, treatment while the progress.  Its of all investigations to the story or her designated to other officials in accordance adding to the State Survey orking days of the incident, and ion is verified appropriate ust be taken.  In it is not met as evidenced we and document review, the ture allegations of abuse and in origin were immediately ininistrator and/or state agency oughly investigated for 2 of 5 in R33) whose allegations of	F 2	F225- Investigate Allegations It is the policy of Talahi Nursin Rehab Center to ensure that a violations involving abuse, ner exploitation or mistreatment, i injuries of unknown source ar misappropriation of resident p reported immediately, but not hours after the allegation is m events that cause the allegatio abuse or result in bodily injury	ng and all alleged glect, ncluding nd property, are later than 2 ade, if the pon involve	
	and had no behavi	ors. R97's care plan dated she had diagnoses of altered		that 24 hours if the events that allegation do not involve abus	t cause the	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		COM	(X3) DATE SURVEY COMPLETED	
		<b>245438</b> B. WING		C <b>12/08/2016</b>			
NAME OF PROVIDER OR SUPPLIER  TALAHI NURSING AND REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE  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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLÉTION		
F 225	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F 225	result in serious bodily injury, administrator of the facility ar officials (including the state s and adult protective services law provides for jurisdiction in care facilities) in accordance law through established proc  The occurrences of R97 and reviewed by the IDT, and con  The policy and procedure for adult was reviewed and is cu  All suspected vulnerable adureported to the DON and Adreper policy guidelines.  DON/Administrator or design complete daily audit of progrand risk management/incider to ensure update immediately incidents and potential VA repart of the policy and is in use to the timely notification and complete investigation. This tool and the will be reviewed weekly and to QA meetings.  Administrator, DON/designed responsible	nd to other urvey agency where state n long-term with State edures.  R33 were npleted.  vulnerable rrent.  It reports are ninistrator  ee will ess notes nt report log y of all ports.  dult reports ensure for etion of ne findings the monthly		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245438	B. WING			C <b>12/08/2016</b>	
NAME OF PROVIDER OR SUPPLIER  TALAHI NURSING AND REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304		00/2010	
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLÉTION		
F 225	morning cares on 1 and two bruises we on the top of her arcm; and one on the measuring 2 cm by bruises located on measuring 2 cm by underside measure indicated the incide agency on 11/15/16 occurred. There wa administrator and s notified of the incide SA on 11/12/16, but 11/15/16 to report the stated once she was immediately reported. Review of the facility Abuse Policy and Pindicated all allegat abuse must be reported or witness neglect a report must he Minnesota Depart also indicated an in	ing R33 by the forearms during 1/12/16. R33 was examined, re found on her left forearm, in measuring two cm by four underside of her arm 2 cm. There were also R33's right forearm, 4.5 cm, and the one on the d 2 cm by 2.5 cm. The report int was reported to the state is, three days after the incident is no indication the state agency was immediately ent.  1/07/16, at 11:15 a.m. the restated the incident "should ately reported to her and the a staff member waited until the incident. The administrator is notified, the incident was ed and investigated.  1/1/28/16, ions and/or suspicious of corted to the administrator is oblicy further indicated if injury allegation of abuse is ed, if there is caregiver is timmediately. The policy ternal, facility investigation of investigation of integration of investigation of integration in integration i	F2	25			
F 226 SS=D	reports will be comp 483.12(b)(1)-(3), 48 DEVELOP/IMPLME POLICIES		F 2	26		1/17/17	

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:			PLE CONSTRUCTION  G	COMPLETED	
		245438	B. WING		C <b>12/08/2016</b>
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  1717 UNIVERSITY DRIVE SOUTHEAST  SAINT CLOUD, MN 56304	1 12/00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 226	Continued From pa	ge 9	F 22	6	
	483.12 (b) The facility mus written policies and	t develop and implement procedures that:			
		vent abuse, neglect, and lents and misappropriation of			
	(2) Establish policie investigate any suc	es and procedures to hallegations, and			
	(3) Include training §483.95,	as required at paragraph			
	the freedom from a requirements in § 4	and exploitation. In addition to buse, neglect, and exploitation 83.12, facilities must also heir staff that at a minimum			
		constitute abuse, neglect, isappropriation of resident h at § 483.12.			
	` , ` ,	or reporting incidents of abuse, n, or the misappropriation of			
	prevention. This REQUIREMEI	anagement and resident abuse			
	facility failed to imp policy and procedu allegation of abuse	v and document review, the lement their abuse prohibition re to immediately report and injuries of unknown origing, state agency and conduct a		F226- Develop Abuse Policies  It is the policy of Talahi Nursing a Rehab Center to ensure that all a violations involving abuse, neglections	ılleged

,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	X2) MULTIPLE CONSTRUCTION   A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245438	B. WING				) 0 <b>8/2016</b>	
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>		ST	REET ADDRESS, CITY, STATE, ZIP CODE	12/	30/2010	
	NURSING AND REH			17	17 UNIVERSITY DRIVE SOUTHEAST AINT CLOUD, MN 56304			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE	
F 226	thorough investiga and R33) allegation. Findings include:  The facility Vulnera Policy and Proced all allegations and reported to the adipolicy further indic or allegation of about there is caregiver immediately be reputed administrator immindicated an intermore reports will be consumed and the consumeration of the injurthorough investigation.	able Adult Protection, Abuse ure dated 11/28/16, indicated for suspicious of abuse must be ministrator immediately. The ated if injury is unexplainable, use is reported or witnessed, if neglect a report must borted to the Minnesota alth (MDH) and to call the ediately. The policy further hal facility investigation of appleted.  hange MDS dated 05/18/16, severely, cognitively impaired iors. R97's care plan dated she had diagnoses of altered	F 2	226	exploitation or mistreatment, includinguries of unknown source and misappropriation of resident propreported immediately, but not late hours after the allegation is made events that cause the allegation is abuse or result in bodily injury, or than 24 hours if the events that callegation do not involve abuse a result in serious bodily injury, to the Administrator of the facility and to officials (including the state surve and adult protective services whe law provides for jurisdiction in lon care facilities) in accordance with law through established procedure.  The occurrences of R97 and R33 reviewed by the IDT, and complete the policy guidelines.  Staff have been re-educated on the vulnerable adult represented to the DON and Administrator or designee where the complete daily audit of progress and reporting guidelines.  DON/Administrator or designee where the complete daily audit of progress and risk management/incident represented to the policy and procedure for vulnerable adult represented to the policy guidelines.	erty, are er than 2 er than 2 er, if the nvolve not later ause the nd do not ne other y agency ere state geterm state es. evere ted. erable it.		
	cm dark, purple ar further indicated R and when asked if and nodded. There administrator and notified of the injust thorough investigathe possible cause facility policy.	ea in the center. The report 197 had no complaints of pain she bumped it, R97 smiled e was no indication the state agency were immediately by of known origin, nor was a tion completed to determine			vulnerable adult reporting and pro and reporting guidelines.  DON/Administrator or designee v complete daily audit of progress r and risk management/incident re to ensure update immediately of	vill notes port log all s.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245438	B. WING				08/ <b>2016</b>
NAME OF F	PROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	12/	00/2010
TALAHI I	NURSING AND REHA	B CENTER			717 UNIVERSITY DRIVE SOUTHEAST AINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	administrator was use thought since I smiled after being a was probably why to the administrator the cognitively impaired reported immediate then investigated, as then investigated, as the was severely of care plan dated 03/impaired thought proceed and the condary to Alzheid difficulty verbalizing assistant (Nourse (RN)-B that a allegedly took placed 11/12/16, with an allimmediately susper rough while grabbing morning cares on 1 and two bruises we on the top of her arcm; and one on the measuring 2 cm by bruises located on measuring 2 cm by underside measure indicated the incide agency on 11/15/16 occurred. There was administrator and so notified of the incide of the	inable to recall the incident. R97 nodded her head and asked if she bumped it, this he incident was not reported. In the resident is at the report should have been by reported to her, SA and is their policy identified.  S dated 09/06/16, indicated ognitively impaired. R33's 02/15, indicated she had rocesses and cognitive status, imer's disease, and had needs.  ated 11/15/16, indicated NA)-H reported to registered a possible abuse incident and during the morning of leged perpetrator, whom was need. NA-H reported she was need to the state of three days after the incident of the state of three days after the incident of the state of the state of three days after the incident of the state of the	F 2	226	timely notification and completion of investigation. This tool and the find will be reviewed weekly and at the monthly QA meetings.  Administrator, DON/designee are responsible		

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X A. BUILDING				(X3) DATE SURVEY COMPLETED	
						(	C	
		245438	B. WING			12/	08/2016	
	PROVIDER OR SUPPLIER	D CENTED			TREET ADDRESS, CITY, STATE, ZIP CODE  17 UNIVERSITY DRIVE SOUTHEAST			
IALAHII	NURSING AND REHA	BCENIER		S	AINT CLOUD, MN 56304			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		BE	(X5) COMPLETION DATE		
F 226	have been" immedi SA on 11/12/16, but 11/15/16 to report the reported once she was	r stated the incident "should ately reported to her and the ta staff member waited until the incident. The administrator was notified, the incident was ed and investigated, as	F 2	226				
F 244 SS=E	483.10(f)(5)(iv)(A)(I GRIEVANCE/RECO (f)(5) The resident I	B) LISTEN/ACT ON GROUP DMMENDATION has a right to organize and	F 2	244			1/17/17	
	(iv) The facility mus resident or family g the grievances and	ent groups in the facility.  It consider the views of a roup and act promptly upon recommendations of such issues of resident care and life						
		t be able to demonstrate their nale for such response.						
	facility must implement request of the resident	be construed to mean that the nent as recommended every ent or family group. NT is not met as evidenced						
	Based on interview facility failed to add to have the adminis council meetings, w	r, and document review, the ress a resident council request strator or DON present during which had the potential to affect 13, R65, R6, R53, R48 and council meetings.			F224- Listen to Group Grievances  Talahi Nursing and Rehab Center d consider the views of the resident c and does act promptly upon the rec resident council.	ouncil		
		imum Data Set (MDS) dated ntact cognition. The MDS also			The DON and Dietary Director atter the November make up council me on 12/9/6 to address any questions concerns that council might have.	eting		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		245438	B. WING			C <b>12/08/2016</b>		
	PROVIDER OR SUPPLIER	B CENTER	l	1	TREET ADDRESS, CITY, STATE, ZIP CODE 717 UNIVERSITY DRIVE SOUTHEAST 6AINT CLOUD, MN 56304	12/0	,0,2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 244	indicated R13 was expressing ideas at known.  R65's quarterly MD cognitive impairment R65 was understood could make her needs was understood when emake his needs known.  R53's quarterly MD moderate cognition indicated R53 was expressing ideas at known.  R48's quarterly MD cognitive impairment R48 was understood could make her needs known.  R30's quarterly MD cognitive impairment R48 was understood when emake her needs known.  During interview on stated she attended meetings. During the was a suggestion nor the DON (director meetings. R13 states and states and suggestion in or the DON (director meetings. R13 states) and suggestion management results and suggestion management results and suggestion in or the DON (director meetings. R13 states) and suggestion management results and suggestion results and suggestion management results and suggestion results and	S dated 11/19/16, indicated and when expressing ideas and eds known.  S dated 10/25/16, indicated and meds known.  S dated 10/25/16, indicated and meds known.  S dated 10/25/16, indicated and meds and could make her needs  S dated 11/19/16, indicated and could make her needs  S dated 11/19/16, indicated and when expressing ideas and eds known.  S dated 9/3/16 indicated intact and could make meds  S dated 9/3/16 indicated intact and could make meds  S dated 9/3/16 indicated intact and could make meds and could meds and could	F 2	244	The DON and Administrator attend December regular council meeting 12/16/16 to address any questions concerns the council might have. Twere no concerns at that time.  R65 and R6 were in attendance at meetings.  R53, R48, and R30 are not identified the state supplied stage 2 sample relist.  The Administrator and the DON were-educated by Regional Director of Operation on, but not limited to the necessity to listen and follow through group and individual grievances.  An audit tool was created to ensure proper follow through after each more resident council meeting. This tool were viewed by each QA meeting.  The DON, Administrator, Dietary Dactivity Director, Maintenance Director and Social Service will be available attend each resident council meeting requested.  Social Service is responsible	on or or here both ed on resident ere of onthly will be irector, ctor eto		

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245438	B. WING _		12	C 2/ <b>08/2016</b>	
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 1717 UNIVERSITY DRIVE SOUTHEAS SAINT CLOUD, MN 56304	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 244	like them partake in added they wouldn't R13 stated it would out." R13 could not administrator preset October resident concept of Resident council must be reviewed. The minus 16, 2016 indicated "Residents express the administrator, of dietary attend meet order for them to have suggestions for impart of the council of the suggestion was not minutes identified meeting, as well as included the social of the council of the cou	t have to stay the whole time. be nice "just to hear us guys t recall seeing the DON or the ent at either the September or	F 24	.4			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245438	B. WING				08/ <b>2016</b>
	PROVIDER OR SUPPLIER	B CENTER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 717 UNIVERSITY DRIVE SOUTHEAST 6AINT CLOUD, MN 56304	12/	50/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 244	In an interview on 1 he frequently attendexpected "honest in the resident, and the afterwards." R6 standinistrator in the good to have the admeetings.  In an interview on 1 worker (SW) stated (AD) assisted in factor the residents, but and DON" did not an not know why the repassed on, and "the also stated it would administrator, the Domeetings. Further, resident council meetings here to discure the council meetings have be present to discure the council meetings have been director of nursing (informed of the council meeting request. The DON "invited" to the courstated she is always units, on a daily bas	2/6/16, at 3:34 p.m. R6 stated ded council meetings and aput" to any question given by en "carry through with it ated he occasionally saw the dining area, but it would be diministrator present at the dining resident council stated they tried to a various staff at the meeting at typically "the administrator attend. The SW stated she did esidents' request was not e ball got dropped." The SW not be difficult for either the BON, or other staff to be at the SW stated at the next eting, administration should se how often they should ted there were no resident eld in November.  12/7/16, at 3:57 p.m., the DON) stated she was not ncil's request, nor received minutes to read about their thought she had to be ncil meeting. Further, the DON is talking with residents on the sis, and that this would be idents, and staff, to talk about	F 2	244			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245438	B. WING		C <b>12/08/2016</b>	
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		D BE	(X5) COMPLETION DATE
F 250 SS=D	5/23/2014, indicate sense of belonging making among the "provide residents grievances that hey suggestion on what further indicated gr meeting should be department," and taddressed "at the residents."  483.40(d) PROVIS RELATED SOCIAL  (d) The facility must social services to a practicable physical well-being of each This REQUIREMED by:  Based on interview facility failed to proviservices to assist refor 1 of 1 residents primary physician.  Findings include:  R31's admission mindicated residents and indicated she had be following a hospital also indicated a foll primary physician and indicated a following a hospital also indicated a foll primary physician and indicated a foll primary physician and indicated a following a hospital also indicat	d its objective "to promote a and community decision residents," and would with the opportunity to air any may have and to give they would like." The policy ievances aided during the "addressed within the proper hat any follow-up can be next Resident Council ION OF MEDICALLY SERVICE  It provide medically-related ttain or maintain the highest I, mental and psychosocial	F2		does ervices esident. and is	1/17/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245438	B. WING			12/0	)8/ <b>2016</b>
	PROVIDER OR SUPPLIER	B CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  1717 UNIVERSITY DRIVE SOUTHEAST  SAINT CLOUD, MN 56304				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 250	infection) along with nephropathy (kidned chronic obstructive). Review of physician notes identified the On 8/31/16, R31 reassessed by her property of the note indicated visits due to her "Acconditions with multi" (Given long-term property of the conditions with multi" (Given long-term property) of the conditions with multi" (Given long-term property) of the conditions with multi" (Given long-term physician) of the conditions with	sion diagnosis of cellulitis (skin ha history of diabetes with by damage), heart failure, and pulmonary disease.  In and physician assistant (PA) following:  In accived a visit and was imary medical doctor (MD-B). Ithat R31 needed monthly dvanced multiple comorbid tiple medications" and that lacement in skilled nursing transfer care."  In a ster her last physician visit, thent to establish care with a many mode identified MD-C would acility to "Clarify the issue non-eligibility for in-facility, many, MD-C declined to take R31 mending an Internal Medicine and to place referral for the safter her admission, R31 had ha PA-A. After assessing declined to take R31 as a complex medical history and internal Medicine Physician.  The safter she was admitted, the ted an assessment of R31 and safter her assessment of R31 and	F 2	50	Health Unit Coordinator maintains a audit to track date of admission and for required re-visits for all new admissions.  Social Services reviews audit track weekly to assure compliance.  An audit of all residents has been completed to assure physician visit compliant.  QAPI will review this audit and make recommendations on it's continuant.  Social Service, Admissions Coordin Health Unit Coordinator, DON are responsible.	er s are ce.	

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245438	B. WING		C <b>12/08/2</b> 0	16
	PROVIDER OR SUPPLIER	B CENTER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304	12/00/20	710
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL		(X5) PLETION DATE
F 257 SS=B	establish care with resident at the nurs. During interview on director (MD)-A stat not assessed by a pashe had subsequer MD-A stated it was primary physician to replacement physician to replacement physician was denied can he would have expenservices to aide in fighth physician.  During interview on worker (SW)-A stated followed by their prince ituation. SW-A stated ituation. SW-A stated followed by their prince ituation. SW-A stated followed b	ed in assisting R31 to a primary physician while a ing the facility.  12/7/16, at 5:29 p.m. medical ted he was unaware R31 was physician in September or that atly been denied care twice. The responsibility of R31's continue care until a ian was found. However, after refrom her primary physician, ected the facility's social inding R31 an appropriate  12/8/16, at 11:03 a.m. social ed residents were typically mary physician, unlike R31's ted she thought the nursing on finding R31 a new all services did not have any 1 to find a physician. ORTABLE & SAFE	F 250	F257- Comfortable Temperatures Talahi Nursing and Rehab Center of maintain safe temperature levels. The windows were closed in R162		/17

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		245438	B. WING			12/0	08/2016
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD  1717 UNIVERSITY DRIVE SOUTHEAST		TREET ADDRESS, CITY, STATE, ZIP CODE		
TALAHI N	NURSING AND REHA	B CENTER	SAINT CLOUD, MN 56304				
(V4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	J	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX (EACH CORRECTIVE ACTION S		BE	COMPLETION DATE
F 257	Continued From no	go 10	Г О	.E.7			
1 237	Continued From pa potential to affect 5	0 residents who used these	F 2	:57	R165 to prevent cooling of these ar	eas.	
	areas. Findings include:				Maintenance was in-serviced to en	curo	
					proper temperatures are maintained		
		on 12/08/16, at 12:47 p.m. an			Maintenance will conduct audits in		
		of the facility was conducted upervisor (MS) who confirmed			random locations five times weekly period of three weeks, and make	tor a	
	the following finding				adjustments as indicated for tempe	ratures	
				outside the parameter of 71-81 de			
	The resident dayroom, located off of the main dining room, was cool. The temperature				Audita will continue weekly for one	mara	
		grees Fahrenheit (F).			Audits will continue weekly for one month after this period.	nore	
		rature in the room measured			QAPI will review audits for complian		
	at 70 degrees F.				regularly scheduled meetings and r recommendations for continuance.	паке	
	In R167 the temper 66 degrees F.	ature in the room measured at			Maintenance will be responsible.		
	oo degrees F.				Maintenance will be responsible.		
	findings listed above practice was for fact with concerns with up in the morning a maintenance staff. checked resident of temperatures in over	3 p.m. MS confirmed all of the e. MS stated the usual facility cility staff to notify maintenance paper slips, which were picked as needed by the Further, MS stated he had not recommon area room er a month because he did not as working on getting around					
F 280 SS=D	but was not provide 483.10(c)(2)(i-ii,iv,v PARTICIPATE PLA 483.10	naintenance was requested, ed during the survey. (3),483.21(b)(2) RIGHT TO NNING CARE-REVISE CP	F 2	80			1/17/17
	(ο,(Ε) της πίχητιο μ	and pate in the development					

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245438	B. WING _			C / <b>08/2016</b>	
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304		, 00, 2010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 280	plan of care, including the right to particulate including the right to be included in the prequest meetings a revisions to the personal control of th	of his or her person-centered ng but not limited to:  cipate in the planning process, or identify individuals or roles to planning process, the right to not the right to request son-centered plan of care.  Icipate in establishing the loutcomes of care, the type, and duration of care, and any do to the effectiveness of the leive the services and/or items of care.  The care plan, including the gnificant changes to the plan hall inform the resident of the nothing of the nothing of the resident and sident in this right. The leust  usion of the resident and/or tive.  It is serviced and and and as in developing goals of care.	F 28	30			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG	COMPLETED
		245438	B. WING _		C <b>12/08/2016</b>
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304	12/00/2010
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F 280	Continued From pa	ge 21	F 28	30	
	(2) A comprehensiv	e care plan must be-			
	(i) Developed withir the comprehensive	n 7 days after completion of assessment.			
	(ii) Prepared by an includes but is not I	interdisciplinary team, that imited to			
	(A) The attending p	hysician.			
	(B) A registered nur resident.	rse with responsibility for the			
	(C) A nurse aide wiresident.	th responsibility for the			
	(D) A member of fo	od and nutrition services staff.			
	the resident and the An explanation must medical record if the and their resident re	racticable, the participation of e resident's representative(s). It is included in a resident's e participation of the resident epresentative is determined the development of the in.			
		te staff or professionals in mined by the resident's needs the resident.			
	team after each ass comprehensive and assessments. This REQUIREMEN	revised by the interdisciplinary sessment, including both the d quarterly review  NT is not met as evidenced			
		tion, interview and document ailed to update the resident		F280-Right to Participate in Pla	nning

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			SURVEY PLETED		
		245438	B. WING				) 08/2016
	PROVIDER OR SUPPLIER	B CENTER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304		, , , , , , , , , , , , , , , , , , , ,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280	plan of care for falls reassessment was (R92) reviewed for Findings include:  R92's diagnoses, a dated 12/8/16, inclufailure, anxiety disc admission Minimum 11/22/16 indicated The care area asset 11/22/16 identified shortness of breath and balance. The working with therapendurance, was mato assist with mobil During observation was seated in her wroom door. R92 wooxygen tubing to tha nasal cannula in a cord, which lead movement-detecting the back of the whole Review of an Investing indicated R92 had a room on 11/20/16. added an interventing personal, movement R92 when in wheel The care plan, revisions at high risk for anticipate and mee	s with new interventions after a completed for 1 of 2 residents falls.  s identified on the face sheet aded chronic respiratory rder and weakness. R92's in Data Set (MDS) dated moderately impaired cognition. It is sment (CAA) for falls dated R92 was at risk for falls due to a with activity, unsteady gait CAA also indicated R92 was by for strengthening and aking progress, and staff were ity and transfers.  on 12/06/16 at 2:22 p.m., R92 wheel chair just outside her ore shoes and socks, had it is right of the wheel chair, with place. Clipped to her shirt was directly to a TABS (a personal, it is gation Report dated 11/22/16 an unwitnessed fall in her The interdisciplinary team on to place a TABS (a int-detecting safety) alarm for	F 2	280	It is the policy of Talahi Nursing and Rehab Cento to establish a care plall residents which accurately reflect needs and strengths and guides st providing resident care. The policy been reviewed and is current.  R92 does not have a TABS alarm. care plan, and nurse Aide care she accurate.  Education was completed for direct staff on following the care plan.  All care plans are reviewed in conjumith the RAI process.  Audits of care provided, per the decare plan, will be conducted on five random residents weekly for two mandom residents weekly for compliant regularly scheduled meetings and recommendations for continuance.  DON or designee is responsible	an for cts their aff in has  The ets are t care unction veloped e onths.  nce at make	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245438	B. WING				C 08/2016
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, 2 1717 UNIVERSITY DRIVE SOUT SAINT CLOUD, MN 56304		12/	55/2010
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F 280	encourage resident promote exercise for resident is wearing fall protocol; and Prand treat. R92's calarm intervention.  Review of the nursi identified R92 requimoderate fall risk, and had a regular of R92's fall intervention.  During an interview nursing assistant (Nand used her nursi sheet, NA-I said the alarm, "but I know alarm on." NA-I staresidents care plan meetings, but it wo care plan, especial  During interview on director of nursing care plan in the resupdated, as well as DON stated the uniand it was a matter "completed and up."  A facility policy titled indicated it is the peall residents have a reflects their needs staff in providing reindicated an interdi	to participate in activities that or strengthening; ensure appropriate footwear; follow T (physical therapy) evaluate are plan lacked the TABS  Ing aide care sheets, undated, ired stand by assist, was a was to bet toiled every 2 hours, diet. The sheet did not include on to use the TABS alarm.  I on 12/8/16 at 10:02 a.m., NA)-I stated she always carrieding sheet. After reviewing the ere was nothing about R92's [R92] is supposed to have the ated she learns of changes to sat the change of shift uld be important to know the lay if you help any new resident.  In 12/8/16 at 10:15 a.m. the (DON) stated R92's working ident's chart should have been at the aide cares sheets. The it managers were responsible, of getting that task dated."  I Careplan revised 3/25/16, policy of Talahi Care Center that a Plan of Care which accurately and strengths, and guides sident care. The policy further sciplinary team is responsible at of the care plan and nursing	F 2	280			

	A. BOILDING		PLETED			
		245438	B. WING _			08/ <b>2016</b>
	PROVIDER OR SUPPLIER  NURSING AND REHA	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 281 SS=D	(b)(3) Comprehens The services providas outlined by the comust-  (i) Meet professional This REQUIREMENT by: Based on interview facility failed to devent the needs of confusion of 1 newly admitted risk for pressure ulder in the facility on 12/01 set had not been confusionable fast, had very potential problem wassessment resulted indicated R94 was developing a press  R94's Individual Recare plan) dated 12 incontinent of bowe on rounds. The terindicate or identify	ded or arranged by the facility, comprehensive care plan, all standards of quality. NT is not met as evidenced a and document review, the elop a care plan, sufficient to a newly admitted resident for 1 aresidents (R94) identified at cers and skin breakdown.  ecord, undated, indicated she neurological disorder. The indicated R94 was admitted to /16, and the Minimum Data ompleted.  essment, dated 12/01/16, occasionally moist skin, was limited mobility and had with friction and shear. The ed a score of 14, which at moderate risk for	F 28	F281- Services Provided to Mee Professional Needs  It is the policy of Talahi Nursing a Rehab Center to establish a tem care plan within 24 hours of adm  R94 initial temporary care plan we establish on admission. This car was reviewed for ADL's toileting and repositioning needs and is cand accurate.  All care plans are reviewed in cowith RAI process.  Education completed to all direct staff on following the care plan a implementing accurate and time plans.  All temporary care plans have be reviewed to ensure that they me residents needs.  Audits of care provided, per the care plan, will be conducted on frandom residents weekly for two	and porary ission.  vas e plan needs urrent  injunction  t care nd ly care  een et the  developed ive	1/17/17

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFICIENCY)	D BE	(X5) COMPLETION DATE
F 281	During observation 8:18 a.m., NA-E sta and that she was so provide cares. NA-someone to help hi 8:30 a.m., and said At 8:34 a.m. NA-E opad that was mode was incontinent of a R94's entire peri- a (damage or remove skin). NA-E stated and applied peri crestated he started at first time during his R94. NA-E said he last changed.  During interview 12 registered nurse (Romage or stated he started at first time during his R94. NA-E said he last changed.  During interview 12 registered nurse (Romage or stated he started at first time during his R94. NA-E said he last changed.  A facility policy titled indicated "It is the put that all residents has accurately reflects to guides staff in provipolicy further indicated admission, a tempo which will accuratel strengths, and guidestated staff in guidestated strengths, and guidestated strengths, and guidestated strengths.	and interview 12/07/16, at ated he was checking on R94, apposed to have two staff to E stated he was going to find m. NA-E returned alone at he was unable to find help. The removed R94's incontinence rately soaked with urine, and a small bowel movement. The was red and excoriated a small bowel movement. The R94's bottom was very red, and to the area. NA-E then a 6:00 a.m. and this was the shift he had provided cares to a did not know when R94 was a compared to the red of the R94's hould be two hours because "she is at down. RN-C then stated this	F 281	Audit of all temporary care plans to the temporary care plan meets the residents needs will be conducted months.  Repositioning and toileting audits conducted on five random resident weekly for the next two months.  QAPI committee will review all audicompliance at regularly scheduled meetings and make recommendation continuance.  DON or designee is responsible	e I for two will be outs	
F 282 SS=E	care. 483.21(b)(3)(ii) SER PERSONS/PER CA	RVICES BY QUALIFIED ARE PLAN	F 282			1/17/17

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION  NG	COMI	
		245438	B. WING _			08/ <b>2016</b>
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 282	as outlined by the omust-  (ii) Be provided by accordance with eacare.  This REQUIREME by: Based on observareview, the facility of care was implement R49, R94 and R87 dependent on staff (ADLs).  Findings include:  BATHING R41's quarterly Mir 11/21/16, identified cognitively impaired from facility staff for (ADL)'s. In addition ADL's during the MR41's plan of care, had an identified purelated to her (R41 plan identified R41 of 1 with ADL's and once a week as reathe care plan noted sponge bath, when tolerated.		F 24	F282- Services Provided by Persons per Care Plan  It is the policy of Talahi Nursir Rehab Center to ensure the pis followed for all residents.  This policy has been reviewer current.  R41 care plan has been reviewer updated to reflect current recepathing needs. The nurse Aid Sheet is accurate.  Staff re-educated on R41 bate documentation.  A recumbent shower chair has ordered to accommodate a function of R41, and other residents as arises.  The care plan for R49 was redietary needs. Nurse Aide Caraccurate.  R94 care plan has been reviewed.	ng and plan of care d and is ewed and eiving bed le Care hing and as been all shower for the need viewed for are Sheet is	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
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	PROVIDER OR SUPPLIER	B CENTER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 717 UNIVERSITY DRIVE SOUTHEAST 6AINT CLOUD, MN 56304	12/0	,0,2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	12:41 p.m. R41 sta weekly scheduled by was concerned bed from facility staff will R41's Body Audit Freceived a tub bath 10/13/16, and 10/5, medical record, the had rejected ADL's through 12/05/16.  During interview on nursing assistant (N should be document the bath book. Furt unaware of R41 ref was a "tough one" to we will be the care plan. Furth baths, "were not hap audit forms.  During interview on director of nursing residents in the fact baths as directed by ASSISIT DEVICES R49's quarterly MD R49 was severely compensations.	ted she had not received bath on a "regular basis" and cause she required assistance th her ADL's.  orm identified R41 had on 11/21/16, 11/10/16, (16. Upon review of R41' s re was no indication that R41 with bathing from 10/05/16  12/07/16, at 6:07 a.m. NA)-J stated all of R41's baths atted on the body audit form in her, NA-J stated she was fusing a bath in the past, but to bathe.  on 12/07/16, at 10:16 a.m. (N)-D stated R41 should be need bath a week according to the path a week according to the re RN-D stated R41's opening "according to the body attended to the body of the care plan.  S dated 10/15/16, indicated cognitively impaired needed	F 2	282	updated to reflect current turning, to and repositioning needs. The nurse care sheet has been updated.  Staff have been re-educated on RS turning, toileting and repositioning in the care plan of R87 was reviewed updated to include direction to staff positioning and nurse aide sheet is accurate.  Staff were re-educated on following care plan.  Audits of care provided, per the decare plan, will be conducted on five random residents weekly for two mandom residents weekly for two mandom residents weekly scheduled meetings and make recommendatic continuance.  DON/designee is responsible.	e aide  94 needs. d and f for g the veloped nonths.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION  ING	` '	MPLETED
		245438	B. WING		1:	C 2/ <b>08/2016</b>
	PROVIDER OR SUPPLIER	AB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODI 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304	E	-,00,2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRE  (EACH CORRECTIVE ACTION SH  CROSS-REFERENCED TO THE APP  DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 282	by staff to eat. Cut cup half full and co the table, coffee sh During observation nursing assistant (I tray along with a cuno ice in the coffee from the cup.  During interview 12 stated she was not they provide to kee Review of Incident a.m., indicated R45 breakfast meal and Immediate interver liquid half full, and temperature; and sin east kitchen to reast kit	a up food as needed, coffee- fill fol with ice prior to placing at hould be luke warm."  1.12/07/2016, at 12:34 p.m.  NA)-G provided R49 her lunch up of coffee 3/4 full. There was and visible steam was coming 2/07/16, at 12:40 p.m. NA-G aware of any interventions up her coffee luke warm.  Teport dated 7/27/16 at 8:30 was given coffee prior to de R49 spilled coffee on her lap. Intions included: fill coffee/hot add ice cubes to cool to room signage placed by coffee carafe demind of new intervention.  Ived a injury from hot coffee ventions were not followed to hal injury.  2/07/16, at 2:22 p.m. registered and she thought R49's coffee m by adding water, and after plan it should have ice placed detected undated indicated she decord undated indicated she decord undated indicated she decord undated indicated she	F 2	82		
	R94's Admission R had dementia and Continence Evalua indicated she was	decord undated indicated she neurological disease. A facility attion form dated 12/06/16, incontinent of bladder, onset ble to sit on the toileted and				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	TIPLE CONSTRUCTION ING	(>	(X3) DATE SURVEY COMPLETED	
		245438	B. WING			C <b>12/08/2016</b>
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, Z 1717 UNIVERSITY DRIVE SOUT SAINT CLOUD, MN 56304		12/00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD B THE APPROPRIA	
F 282	was not motivated to R94's Individual Recare plan) dated 12 incontinent of bowerounds (every two hindicated R94 was to reposition herself R94's nursing assist instructed staff to to hours.  During continuous of 6:00 a.m. to 8:34 a. R94 was lying in heher nightgown on. observed during this assistant (NA)-E loowalked by. At 8:13 room stated he was provide R94 with ar re-entered the room which was moderated a small bowel move was red and excoris of the surface of the bottom was very rethe area. NA-E stated and this was the first provided cares to Recombination of the surface of the bottom was the first provided cares to Recombination of the surface of the bottom was the first provided cares to Recombination of the surface of the bottom was the first provided cares to Recombination of the surface of the bottom was the first provided cares to Recombination of the surface of the bottom was the first provided cares to Recombination of the surface of the bottom was the first provided cares to Recombination of the surface of the surface of the bottom was the first provided cares to Recombination of the surface of the surface of the surface of the bottom was the first provided cares to Recombination of the surface of the surfa	sident Care Plan (temporary /1/16, indicated she was I and bladder and toilet on nours). The care plan high risk for falls, was unable f.  stant care sheet, undated, bilet the resident every two observation on 12/07/16, from m. (2 hours and 34 minutes) r bed on her right side with There was no staff for R94 stime. A 7:52 a.m. nursing oked into R94's room and a.m. NA-E entered R94's checking on R94, but did not my cares. At 8:34 a.m. NA-E and removed R94's pad ely soaked with urine, and had ement. R94's entire peri- area ated (damage or remove part e skin). NA-E stated her d, and applied peri cream to ted he started at 6:00 a.m. st time during his shift he had 194. NA-E said he did not	F 2	282		

-	ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION IDENTIFICATION NUMBER: (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245438	B. WING		1:	C 2/ <b>08/2016</b>
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 1717 UNIVERSITY DRIVE SOUTHEA SAINT CLOUD, MN 56304	ODE	2,00,2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 282	FALL INTERVENTI R87's admission M 10/4/16, identified F impaired, used a wi was at risk for falls activities of daily livi R87's care plan, da high risk for falls an "Dycem non-slip ma at all times while re care plan did not did cushion to the whee  During observation was seated in his wand no Dycem was During the evening again observed sea Dye was present in observation on 12/8 seated in his wheel Dycem was observed  During interview on assistant (NA)-F sta Dycem in his wheel unaware of dycem was needed in R87  During interview on director of nursing ( were communicate meetings. The DO expected to remem implementing them  A policy regarding in	ONS inimum Data Set (MDS), dated R87 was mildly, cognitively heelchair for locomotion, and and dependent upon staff for ing.  Ited 11/8/16 identified R87 at ad included interventions for aterial to remain in wheelchair sident is up in chair." R87's rect staff to fasten the wedge elchair.  On 12/7/16, at 1:36 p.m., R87 wheelchair while eating lunch. observed in the wheelchair. meal at 4:48 p.m., R87 was ated in his wheelchair, and no the wheelchair. During R8/16, at 9:09 a.m. R87 was chair during breakfast, and no ed in R87's wheelchair.  12/8/16, at 9:16 a.m. nursing ated R87 did not have any chair. NA-F stated she was being a fall intervention, or 's wheel chair.  12/8/16 at 11:13 a.m., the DON) stated fall interventions d to staff daily at morning N further stated staff were ber the interventions, and be	F 2	82		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		COM	(X3) DATE SURVEY COMPLETED			
		245438	B. WING _			C <b>08/2016</b>
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304	E	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 312 SS=D	(a)(2) A resident whactivities of daily living services to maintain personal and oral hand the personal the personal and the personal the pe	no is unable to carry out ng receives the necessary ngood nutrition, grooming, and ygiene.  NT is not met as evidenced ion, interview, and document ailed to provide baths and stance for 2 of 3 residents d that were dependent upon daily living (ADLs).  Imum Data Set (MDS) dated R41 was moderately and required total assistance n, R41 had no rejection of DS assessment period.  Idated 10/06/16, noted R41 had m for ADL self-care deficit s) dementia. Further, the care required an extensive with ADL's and was to receive reek as requested by R41. In an noted R41 was to be both when a full bath could not with R41 on 12/05/16, at ted she had not received eaths on a "regular basis "and ause she required assistance"	F 31	312-ADL Care Provided For E Residents.  Talahi Nursing and Rehab Cer provide residents whom are urcarry out activities of daily livin services to maintain personal and timely toileting assistance R41 and R49 were assessed in plans reviewed for bathing and needs.  Education was provided to state following the care plan and produced in the care plan.  Education was provided on compatching sheets.  Audits of care provided, per the care plan, will be conducted on random residents weekly for the care plan, will be conducted on the care plan and the ca	nter does hable to g with hygiene, for and care d toileting  ff on oviding care mpletion of e developed n five wo months. I audits for uled	1/17/17

OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			COMPLETED	
	245438	B. WING				C <b>08/2016</b>
PROVIDER OR SUPPLIER	B CENTER		<b>17</b> 1	7 UNIVERSITY DRIVE SOUTHEAST	12/	00/2010
(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD	) BE	(X5) COMPLETION DATE
received a tub bath 10/13/16, and 10/5/medical record, the R41 rejecting ADL's 12/05/16.  During interview on nursing assistant (National Should be document the bath book. Furtunaware of R41 refewas a "tuff one "to When interviewed or registered nurse (Perceiving at least of R41's baths "were the body audit form completed.  During interview on director of nursing residents depended receiving their bath Review of a facility 10/2013, identified, bath per care plant R94's Admission Radmitted 12/01/16, neurological disease and an admission Nature 1894's Individual Reference of Nature 1994's Individual Reference 1994's Individual Reference 1995/16 (1994) Individual Reference 1995/16 (1995) Individual Reference	on 11/21/16, 11/10/16, (16. Upon review of R41's re was no documentation of a from 10/05/16 through  12/07/16, at 6:07 a.m. NA)-J, stated all of R41's baths need on the body audit form in her, NA-J stated she was rusing a bath in the past and boath.  on 12/07/16, at 10:16 a.m. N)-D stated R41 should be ne bath a week. RN-D stated not happening "according to as, and should have been  12/07/16, at 11:26 a.m. with (DON) stated she was aware not upon staff, were not s.  policy titled, "Tub Bath" dated "all residents will receive a and the policy."  ecord undated indicated she had dementia and se. R94 was newly admitted, Minimum Data Set (MDS) was resident Care Plan (temporary)	F3	312			
	PROVIDER OR SUPPLIER  SUMMARY STA  (EACH DEFICIENCY REGULATORY OR L  Continued From pa received a tub bath 10/13/16, and 10/5/ medical record, the R41 rejecting ADL's 12/05/16.  During interview on nursing assistant (N should be documenthe bath book. Furt unaware of R41 ref was a "tuff one "to I  When interviewed or registered nurse (R receiving at least of R41's baths "were the body audit form completed.  During interview on director of nursing or residents depender receiving their bath  Review of a facility 10/2013, identified, bath per care plan a  R94's Admission R admitted 12/01/16, neurological diseas and an admission N not yet completed.  R94's Individual Re dated 12/1/16, indice	PROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 32 received a tub bath on 11/21/16, 11/10/16, 10/13/16, and 10/5/16. Upon review of R41's medical record, there was no documentation of R41 rejecting ADL's from 10/05/16 through 12/05/16.  During interview on 12/07/16, at 6:07 a.m. nursing assistant (NA)-J, stated all of R41's baths should be documented on the body audit form in the bath book. Further, NA-J stated she was unaware of R41 refusing a bath in the past and was a "tuff one "to bath.  When interviewed on 12/07/16, at 10:16 a.m. registered nurse (RN)-D stated R41 should be receiving at least one bath a week. RN-D stated R41's baths "were not happening "according to the body audit forms, and should have been completed.  During interview on 12/07/16, at 11:26 a.m. with director of nursing (DON) stated she was aware residents dependent upon staff, were not receiving their baths.  Review of a facility policy titled, "Tub Bath" dated 10/2013, identified, "all residents will receive a bath per care plan and the policy."  R94's Admission Record undated indicated she admitted 12/01/16, had dementia and neurological disease. R94 was newly admitted, and an admission Minimum Data Set (MDS) was	PROVIDER OR SUPPLIER  NURSING AND REHAB CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 32 received a tub bath on 11/21/16, 11/10/16, 10/13/16, and 10/5/16. Upon review of R41's medical record, there was no documentation of R41 rejecting ADL's from 10/05/16 through 12/05/16.  During interview on 12/07/16, at 6:07 a.m. nursing assistant (NA)-J, stated all of R41's baths should be documented on the body audit form in the bath book. Further, NA-J stated she was unaware of R41 refusing a bath in the past and was a "tuff one "to bath.  When interviewed on 12/07/16, at 10:16 a.m. registered nurse (RN)-D stated R41 should be receiving at least one bath a week. RN-D stated R41's baths "were not happening "according to the body audit forms, and should have been completed.  During interview on 12/07/16, at 11:26 a.m. with director of nursing (DON) stated she was aware residents dependent upon staff, were not receiving their baths.  Review of a facility policy titled, "Tub Bath" dated 10/2013, identified, "all residents will receive a bath per care plan and the policy."  R94's Admission Record undated indicated she admitted 12/01/16, had dementia and neurological disease. R94 was newly admitted, and an admission Minimum Data Set (MDS) was not yet completed.  R94's Individual Resident Care Plan (temporary) dated 12/1/16, indicated she was incontinent of	PROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 32  received a tub bath on 11/21/16, 11/10/16, 10/13/16, and 10/5/16. 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R94's Admission Record undated indicated she admitted 12/01/16, had dementia and neurological disease. R94 was newly admitted, and an admission Minimum Data Set (MDS) was not yet completed.  R94's Individual Resident Care Plan (temporary) dated 12/11/16, indicated she was incontinent of	PROVIDER OR SUPPLIER  1245438  1245438  1245438  125TREET ADDRESS, CITY, STATE, ZIP CODE  1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304  125 SUMMARY STATEMENT OF DEFICIENCIES (CACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  126 COntinued From page 32  127 received a tub bath on 11/21/16, 11/10/16, 10/13/16, and 10/5/16. Upon review of R41's medical record, there was no documentation of R41 rejecting ADL's from 10/05/16 through 12/05/16.  127 During interview on 12/07/16, at 6:07 a.m. nursing assistant (NA)-J, stated slid of R41's baths should be documented on the body audit form in the bath book. Further, NA-J stated she was unaware of R41 refusing a bath in the past and was a "tuff one "to bath.  When interviewed on 12/07/16, at 10:16 a.m. registered nurse (RN)-D stated R41's baths "were not happening" according to the body audit forms, and should have been completed.  During interview on 12/07/16, at 11:26 a.m. with director of nursing (DON) stated she was aware residents dependent upon staff, were not receiving at least one bath week. RN-D stated R41's baths "were not happening" according to the body audit forms, and should have been completed.  During interview on 12/07/16, at 11:26 a.m. with director of nursing (DON) stated she was aware residents dependent upon staff, were not receiving their baths.  Review of a facility policy titled, "Tub Bath" dated 10/2013, identified, "all residents will receive a bath per care plan and the policy."  R94's Admission Record undated indicated she admitted 12/01/16, had dementia and neurological disease. R94 was newly admitted, and an admission Minimum Data Set (MDS) was not yet completed.	ROVIDER OR SUPPLIER  122  ROVIDER OR SUPPLIER  RURSING AND REHAB CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION)  COntinued From page 32  received a tub bath on 11/21/16, 11/10/16, 10/13/16, and 10/5/16. Upon review of R41's medical record, there was no documentation of R41 rejecting ADL's from 10/05/16 through 12/05/16.  During interview on 12/07/16, at 6:07 a.m. nursing assistant (NA)-J, stated all of R41's baths should be documented on the body audit form in the bath book. Further, NA-J stated she was unaware of R41 refusing a bath in the past and was a "tuff one" to bath.  When interviewed on 12/07/16, at 10:16 a.m. registered nurse (RN)-D stated R41 should be receiving at least one bath a week. RN-D stated R41's baths "were not happening" according to the body audit forms, and should have been completed.  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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245438	B. WING				C <b>08/2016</b>
NAME OF F	PROVIDER OR SUPPLIER			STREET ADD	RESS, CITY, STATE, ZIP CODE	12/	00/2010
TALAHI N	NURSING AND REHA	B CENTER		_	RSITY DRIVE SOUTHEAST DUD, MN 56304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EA	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 312	An untitled and und sheet, identified RS hours.  A Continence Evaluation 12/06/16, indicated bladder and wore afurther indicted it was urge to void and did During continuous 6:00 a.m. to 8:34 a R94 was lying in heher nightgown on. observed during the assistant (NA)-E lowalked by. At 8:13 room stated he was provide R94 any care-entered the roor which was modera a small bowel move was red and excoriof the surface of the bottom was very rethe area. NA-E stated R94 was increported (R94) was reported (R94)	dated nursing assistant care at was to be toileted every two duation assessment dated 1 R94 was incontinent of a brief. The assessment as unknown if R94 had an id not use the toilet.  Observation on 12/07/16, from i.m. (2 hours and 34 minutes) or bed on her right side with There was no staff for R94 is time. A 7:52 a.m. nursing oked into R94's room and a.m. NA-E entered R94's is checking on R94, but did not ares. At 8:34 a.m. NA-E in and removed R94's pad tely soaked with urine, and had ement. R94's entire peri- area ated (damage or remove part in e skin). NA-E stated her in and applied peri cream to ated he started at 6:00 a.m. is time during his shift he had a R94. NA-E said he did not as last changed.  2/07/16, at 1:10 p.m. RN-C is dependent upon staff and at lown, and should be checked	F3	12			
F 314 SS=D	483.25(b)(1) TREA		F3	14			1/17/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED C	
		245438	B. WING		12/08/2016
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 314	(i) A resident receive professional standar pressure ulcers and ulcers unless the indemonstrates that (ii) A resident with professional standar healing, prevent inform developing. This REQUIREME by:  Based on observative review the facility facts assistance for toile reduce the risk of pressure ulcers.  Findings include:  R94's undated Adm was admitted on 12 diagnoses of demedisease in which that the protective coadmission Minimur completed.  A Braden Skin assepressure ulcer risk's pressure ulcer risk	s. Based on the sessment of a resident, the	F 314	F314- Treatment to Prevent Press Sores  Talahi Nursing and Rehab Center provide care consistent with professtandards of practice to prevent prulcers.  R94 was comprehensively re-assefor skin risk.  R94 care plan was reviewed and is current.  All residents identified as at risk for pressure ulcer development have reviewed to assure accuracy and the ensure they are receiving appropricare.	does ssional essure essed r been o

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245438	B. WING				C 0 <b>8/2016</b>
	PROVIDER OR SUPPLIER	B CENTER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	had very limited moof friction and shea score of 14 which in risk for developing and the care plan) dated 12 incontinent of bowe toileted on rounds. Indicate she was at During continuous of 6:00 a.m. to 8:34 a. R94 was lying in he her nightgown on. observed during this assistant (NA)-E lower was red and said he would not provide R94 and re-entered the room which was moderat a small bowel move was red and excorisof the surface of the bottom was very rethe area. NA-E state and this was the first provided cares to Fix know when R94 was During interview 12 nurse (RN)-C state urine, and at risk for be checked/change repositioned during A facility policy "President of the surface of the provided cares to Fix and at risk for the checked/change repositioned during and at risk for the surface of the provided cares to Fix and at risk for the surface of the provided cares to Fix and at risk for the surface of the provided cares to Fix and at risk for the surface of the provided cares to Fix and at risk for the surface of the provided cares to Fix and at risk for the surface of the provided cares to Fix and at risk for the surface of the provided cares to Fix and at risk for the surface of the provided cares to Fix and at risk for the surface of the surface	bility, with a potential problem r. The assessment had a dicated R94 was at moderate a pressure ulcer.  sident Care Plan (temporary /1/16, indicated R94 was I and bladder and was to be R94's care plan did not risk for pressure ulcers.  bbservation on 12/07/16, from m. (2 hours and 34 minutes) r bed on her right side with There was no staff for R94 is time. At 7:52 a.m. nursing oked into R94's room and a.m. NA-E entered R94's ras checking on R94, but did y cares. At 8:34 a.m. NA-E in and removed R94's pad ely soaked with urine, and had ement. R94's entire peri- area ated (damage or remove part e skin). NA-E stated her d, and applied peri cream to ted he started at 6:00 a.m. ist time during his shift he had 194. NA-E said he did not is last changed.	F3	314	The policy for prevention and treatr pressure ulcers/skin breakdown wareviewed and is current.  The policy for evaluation of skin ris reviewed and is current.  Education was provided to clinical the policy and procedure for prever pressure ulcers/skin breakdown.  Audits of care provided, per develocare plan, will be conducted on five random residents weekly for two mafter which the IDT will review and further recommendations.  QAPI committee will review all audic compliance at regularly scheduled meetings and make recommendatic continuance.  DON/designee is responsible	k was staff on of ped onths. make	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245438	B. WING			C / <b>08/2016</b>	
NAME OF PROVIDER				STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304	12/	00/2010	
	CH DEFICIENC	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH CORRESPONDED TO THE APPROPRIES OF T	ULD BE	(X5) COMPLETION DATE	
"Prope clinical skin int preven approp	conditions in egrity, and p tative measi	nd assess residents who's ncrease the risk for impaired bressure ulcers, to implement ures, and to provide ent modalities for wounds	F3	114			
F 315 SS=D  (e) Inco (1) The contine receive contine or beco to mair  (2)For on the facility  (i) A re indwell resider cathete  (ii) A re indwell is asse as posi demon and  (iii) A re receive preven	(e)(1)-(3) NO DRE BLADD ontinence. In facility muse of facility muse of bladders services a sence unless of the facility muse of the facility muse of the facility of the faci	t ensure that resident who is r and bowel on admission and assistance to maintain his or her clinical condition is nat continence is not possible ith urinary incontinence, based emprehensive assessment, the	F3	115		1/17/17	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION  NG	COM	E SURVEY PLETED
		245438	B. WING _			C 08/2016
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 315	(3) For a resident won the resident's confacility must ensure incontinent of bowe treatment and serv bowel function as parties of the treatment and serv bowel function as parties REQUIREMED by:  Based on interview facility failed to conchange in continen (R38) reviewed for  Findings include:  R38's admission Mo8/04/16, indicated urine. The quarterly indicated R38 was (7 or more episode one episode of conassessment (CAA) was on a diuretic (rassistance with toil identified R38 did indue to cognitive imtoilet R38 every two R38's care plan darrequired extensive  A Bladder 7 Day Dotthru 8/4/16, indicate of urine. A subsequince 10/26/16 thru 11/1/incontinent of urine	with fecal incontinence, based omprehensive assessment, the enthal a resident who is ell receives appropriate ices to restore as much normal possible.  Nor is not met as evidenced and and document review, the apprehensively reassess a ce status for 1 of 3 residents urinary incontinence  inimum Data Set (MDS) dated R38 was always continent of a MDS dated 10/31/16, frequently incontinent of urine sof incontinence but at least tinence). The care area dated 8/10/16, identified R38 educes fluid), and needed eting. Further, the CAA ot always ask for assistance upairment, and staff were to	F 31	F315-No catheter, Prevent UTI Bladder  Talahi Nursing and Rehab Cent provides appropriate treatment services to residents to restore to the extent possible.  The assessment tool for evalua urinary continence has been regis current.  R38 has completed a seven da reassessment for bladder continuithe care plan and care assessment have been updated to reflect the status.  Residents identified as incontinuiting reviewed to ensure they are recaccurate assessments, and appropriate assessments.  The bowel and bladder assessment procedure has been review current.  Staff have been re-educated to and bladder assessment policy procedure.	ter and continence and viewed and yenence, and nent sheet e current ent were beiving propriate ment policy yed and is the bowel	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245438	B. WING			08/ <b>2016</b>
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304	, , ,	00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 315	indicated R38 did n without incontinence to toilet and was for assessment on 11/continence was left from continent to fire there were no channelp eliminate or properties. During interview 12 family member (FN and dribbled urine.  During observation assistant (NA)-F as was continent of uring interview 12 nurse (RN)-D states but now was frequent RN-D stated she contour to the Bladder 7-Danurses on the floor completing the assistant director of made changes if no A facility policy titled Assessment policy 08/2016, indicated assessment will embowel or bladder in appropriate treatments.	er assessment dated 11/1/16 ot always void appropriately e, was independent, but slow getful. This portion of R38's 1/16 to indicate changes in blank. Although R38 went equently incontinent of urine, ges to R38's interventions to event the incontinence.  ///////////////////////////////////	F 315	The facility will complete three at week for three weeks on bowel a bladder assessments, and approtreatments and services indicate those assessments.  QAPI committee will review all at compliance at regularly schedule meetings and make recommend continuance.  DON/designee is responsible	and opriate d by udits for	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245438	B. WING			C <b>12/08/2016</b>	
	PROVIDER OR SUPPLIER			17	TREET ADDRESS, CITY, STATE, ZIP CODE 717 UNIVERSITY DRIVE SOUTHEAST AINT CLOUD, MN 56304	12/(	00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 323 F 323 SS=E	(d) Accidents. The facility must en  (1) The resident en	1)-(3) FREE OF ACCIDENT VISION/DEVICES	F 3				1/17/17
	(n) - Bed Rails. The appropriate alternation bed rail. If a bed or must ensure corrections.	eceives adequate supervision rices to prevent accidents.  e facility must attempt to use tives prior to installing a side or side rail is used, the facility et installation, use, and drails, including but not limited ments.					
	from bed rails prior  (2) Review the risks the resident or resident or resident formed consent p  (3) Ensure that the appropriate for the This REQUIREMENT by:  Based on observative review, the facility formed consent p	s and benefits of bed rails with dent representative and obtain			F323 Free of Accidents Talahi Nursing and Rehab Center a	ssures	
	(R87, R49, R75, R3 addition, the facility properly fastened a	hazards for 4 of 5 residents 37) reviewed for accidents. In failed to ensure bed rails were nd secured to the bed frame or 1 of 20 residents (R3) who			each resident receives adequate supervision to prevent accidents.  R87 care plan was reviewed and is current.		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION		PLETED
		245438	B. WING		12/0	)8/2016
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304	1 12/0	70/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 323	10/4/16, identified Fused a wheelchair for falls.  R87's admission Cadated 10/10/16, iderelated to unsteady The CAA also indicamaintaining balance would "Lean back a legs."  Facility Incident Reto 11/26/16, identification facility since admiss 10/22/16, indicated slid out of R87's whather floor. The report sheet) was placed it to the care plan.  R87's care plan, dawas a high risk for fithe intervention "Dyremain in wheelchaup in chair." R87's crecieved a new who fall prevention.  During observation was seated in his wand no dycem was During the evening	inimum Data Set (MDS), dated 887 was cognitively impaired, for locomotion, and was at risk are Area Assessment (CAA), ntified R87 was at risk for falls gait and impaired balance. ated R87 had difficulty while sitting, indicating R87 at times he will straighten his ports, reviewed from 10/9/16 and R87 had seven falls in the sion. An incident report, dated R87's wheelchair cushion had be elchair causing him to fall to at indicated Dycem (non skid on R87's wheelchair and added sted 11/8/16, identified R87 falls. R87's care plan included from non-slip material is to are plan also indicated he elchair cushion to assist with on 12/7/16, at 1:36 p.m., R87 wheelchair while eating lunch, observed in the wheelchair, meal at 4:48 p.m., R87 was ated in his wheelchair, and no	F 323	Fall prevention policy was reviewe current.  R49 care plan was reviewed and is current.  R75 care plan was reviewed and is current.  R3 side rails were secured at time survey, and maintenance checks to retails daily to assure they are secured.  Staff were re-educated on approprinterventions to reduce the risk of to resident altercations, falls and for the care plan to prevent accidents.  Maintenance performs three randoudits weekly for three weeks to asside rails are secure.  All beds with rails have been checkensure they are tightly secured.  Dietary conducts three audits week three weeks to assure dietary guidare being followed.  QAPI committee will review all aud compliance at regularly scheduled meetings and make recommendate continuance.  DON/designee, Maintenance Direct Dietary Director are responsible.	of hese ure. riate resident ollowing om ssure ked to kly for elines dits for tions for	

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION  NG		TE SURVEY MPLETED
		245438	B. WING _		12	C 2/ <b>08/2016</b>
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 1717 UNIVERSITY DRIVE SOUTHEA SAINT CLOUD, MN 56304	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	observation on 12/8 seated in his wheel dycem was observed.  During interview on assistant (NA)-F stain his wheelchair. Nof dycem being a fafor R87's wheel charton of the dycem being a fagor R87's wheel charton on the dycem recieved the new was provided a non slip plan had not been a dycem.  During interview on occupational therapthe dycem in his was cushion did not prosurface.  During interview on director of nursing were communicate meetings. The DO expected to rememing them.  A facility policy titled 9/1/16, directed all would be assessed.	t in the wheelchair. During 3/16, at 9:09 a.m. R87 was chair during breakfast, and no ed in R87's wheelchair.  12/8/16, at 9:16 a.m. nursing ated R87 did not have dycem IA-F stated she was unaware all intervention, or was needed air.  12/8/16, at 9:38 a.m., IN)-C stated R87 no longer in his wheelchair once R87 theelchair cushion, which surface. RN-C stated the care revised to discontinue the revised to discontinue the revised an appropriate non slip  12/8/16 at 10:02 a.m. bist (OT)-A stated R87 needed neelchair, and his wheelchair vide an appropriate non slip  12/8/16 at 11:13 a.m., the (DON) stated fall interventions d to staff daily at morning N further stated staff were aber the interventions, and be deed to the facility for fall risk. The fall ecare plan and assessment	F 3:	23		

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		245438	B. WING			C <b>12/08/2016</b>
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIF 1717 UNIVERSITY DRIVE SOUTH SAINT CLOUD, MN 56304		12/00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATI	(X5) COMPLETION DATE
F 323	R49's quarterly MD R49 was severely of needed supervision  A Progress Note daindicated R49 had moving cup to her releft arm and lap. Releft arm approximated reddened area on 13".  A Risk Managemer indicated "Client was room for breakfast. prior to getting mean breakfast client granter mouth and accident left arm and lap in place for staff to half full and add icciprior to serving, signed.	Inge 42 IS dated 10/15/16, indicated cognitively impaired, and in and set up with eating.  Inted 7/27/16, at 11:34 a.m. picked up the coffee cup, was mouth spilled the hot coffee on eddened area appeared on tely "5' (inches) by 2", lap was eft leg 8" by 4", right leg 7" by as sitting at table in dinning Client was given beverages al. While client was waiting for bbed the cup, moved it toward identally spilled her coffee on o." Writer placed intervention fill coffee/hot liquid containers a cubes to cool to room temp nage placed in front of the last kitchen to remind staff of	F3			
	resident required a cueing by staff to e coffee fill cup half-f placing at the table  During observation nursing assistant (I lunch tray along wit There was no ice ir observed coming fill During interview on	ted 08/10/16, indicated "This mechanical soft diet and at. Cut up food as needed, ull and cool with ice prior to, coffee should be luke-warm."  12/07/2016, at 12:34 p.m., NA)-G provided R49 with her ch a cup of coffee 3/4 full. In the coffee, and steam was from the top of the coffee cup.				

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		245438	B. WING			C <b>12/08/2016</b>	
	PROVIDER OR SUPPLIER	B CENTER		171	REET ADDRESS, CITY, STATE, ZIP CODE  17 UNIVERSITY DRIVE SOUTHEAST  AINT CLOUD, MN 56304	12/	33/2313
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	During interview on registered nurse (F should be luke war then stated R49's obe placed in her cu water. RN-B thoughad changed.  RESIDENT TO RE R75's quarterly Min 11/5/16, indicated simpaired and depre R75's care plan da had a behavior of r staff, related to der disturbance. The assist R75 to devel of coping and interato express feelings  R37's quarterly MD was severely, cogn diagnoses which in A progress note da indicated R75 was another resident (F instructed R75 to s resident's personal agitated. R75 walk sided upper body hand hit R75 in the F injuries. R75 was a	p R49's coffee luke warm.  112/07/16, at 2:22 p.m., RN)-B stated R49's coffee m by adding water. RN-B care plan indicated ice should p to keep it luke warm, not that intervention for R49  SIDENT ALTERCATION himum Data Set (MDS) dated she was severely cognitively essed.  Ited 09/29/16, indicated she epeatedly asking for certain hentia with behavior care plan directed staff to op more appropriate methods acting, and to encourage R75 appropriately.	F3	323			

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING		COMPLETED		
		245438	B. WING			C <b>12/08/2016</b>
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 1717 UNIVERSITY DRIVE SOUTHEA SAINT CLOUD, MN 56304	ODE	12/00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
F 323	room and no furthe  An Incident Report on 10/12/16, in the standing near R37, Staff offered R75 regive R37 some persome agitation towawas in Broda chair wheelchair) and R7 walker. She preced her a left sided hug make a fist with her  Although staff offerenthe altercation with with interventions in after R37 struck R7 resident to resident residents safe.  LOOSE SIDE RAIL R3's quarterly Mining 8/11/16 identified R required extensive daily living (ADL's), morbid obesity and weakness.  During observation bed was fittend with approximately 24" (height. The rails we with a screw. Whe moved back and fo bed frame.  During interview on	dated 10/13/16, indicated that afternoon staff had noted R75 showing concern for her. eassurance and asked her to sonal space as R37 displayed ards others at this time. R37 (tilting and reclining 5 was ambulating using her ed to walk up to R37 and gave. R37 then proceeded to right hand and strike R75. ed reassurance to R75 before R37. There was no change inplemented for either resident, 75, to help reduce the risk of altercations and keep both	F3	323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245438	B. WING			C
NAME OF F	PROVIDER OR SUPPLIER	243430	B. Willa	STREET ADDRESS, CITY, STATE, ZIP CODE	12/	08/2016
	NURSING AND REHA	B CENTER		1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		LD BE	(X5) COMPLETION DATE
F 323	Further, RN-E state rails to assist her in When interviewed of stated the side rails and were difficult to loose.  During interview on registered nurse (R'wobbly" which place and may become a rails became any loo On 12/08/16, at 1:0 facility practice was maintenance with of Further, MS stated for side rail mainter Review of policy titlidentified staff mem rail is safe, provide utilized within manu 483.45(d) DRUG RUNNECESSARY DO (d) Unnecessary Do drug regimen must drugs. An unneces used	d was a safety risk for R3. d R3 frequently used the side a sitting up in bed.  on 12/05/16, at 3:22 p.m. R3 had always been "very loose" use when they were that  12/05/16, at 6:53 p.m. the side rails felt the side the resident at risk for falls an entrapment risk if the side obser.  3 p.m. MS stated the usual for facility staff to notify concerns with paper slips. There was no system in place mance.  ed, "Side Rails" dated 6/11/16 hibers are to assess the side education to residents and are ufacture's instructions.  EGIMEN IS FREE FROM PRUGS  rugs-General. Each resident's be free from unnecessary sary drug is any drug when see (including duplicate drug)	F3	323		1/17/17

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	PROVIDER OR SUPPLIER	B CENTER		17	TREET ADDRESS, CITY, STATE, ZIP CODE 717 UNIVERSITY DRIVE SOUTHEAST AINT CLOUD, MN 56304	1-7	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B TAG CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			(X5) COMPLETION DATE
F 329	(5) In the presence which indicate the or discontinued; or  (6) Any combination paragraphs (d)(1) to This REQUIREMED by: Based on interview facility failed to ensinterventions and becompleted prior to a medications for 1 or for unnecessary medications for 1 or unnecessary medications include:  R80's quarterly Min 08/11/16, indicated impairment with a cand anxiety disorded R80's Care Area As 11/15/16, noted R8 psychosis and requone with activities or R80's care plan day had an identified pranti-anxiety medical anxiety disorder." In monitor/record occ symptoms and doc	tte monitoring; or  tte indications for its use; or  of adverse consequences dose should be reduced or  ns of the reasons stated in hrough (5) of this section.  NT is not met as evidenced  v, and document review, the ure non-pharmacological ehavior monitoring were administering anti-anxiety f 5 residents (R80) reviewed edications.  simum Data Set (MDS) dated R80 had no cognitive diagnosis of major depressive	F3	329	F329 Drug Regimen is Free from Unnecessary Drugs  Talahi Nursing and Rehab Center of ensure that residents are free from unnecessary dru7ggs without adequindications.  R80 care plan was updated to inclusigns and symptoms of anxiety and non-pharmacological approaches that attempt prior to administration of lorazepam.  The psychotropic medications use guideline policy was reviewed and updated.  All residents who receive PRN psychotropic medications were revito ensure non-pharmaceutical interventions are in place and attemprior to medication administration.  Audit to ensure non-pharmaceutical interventions are trialed prior to medication administration up to five	uate ude u u u u u u u u u u u u u u u u u	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(2) MULTIPLE CONSTRUCTION . BUILDING			(X3) DATE SURVEY COMPLETED	
		245438	B. WING			C <b>12/08/2016</b>		
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	12/0	30/2010	
				1717 UNIVERSITY DRIVE SOUTHEAST				
TALAHII	NURSING AND REHA	B CENTER		SAINT CLOUD, MN 56304				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 329	to 2:28 p.m. R80 exanxiety. During obsa.m. to 8:30 a.m., Fanxiety.  Review of R80's medicated R8 (medication used to (mg) tablet every 6 disorder. Further, the were to document sonon-pharmacologic effectiveness before medication.  Review of the MAR In August 2016, R8 lorazepam on 2 difference episodes did not idenon-pharmacologic In September 2016 lorazepam on 10 diabove episodes nonon-pharmacologic attempted prior to the In October 2016, Relorazepam, and signon-pharmacologic attempted prior to the There was no indicativas being given.	on 12/6/16 between 1:45 p.m. chibited no outward signs of servation on 12/7/16 from 6:00 880 presented no signs of dedication administration record to had an order for lorazepam of treat anxiety) 0.25 milligrams hours as needed for anxiety ne order specified facility staff signs of anxiety, all interventions used and its eladministering the dentified the following:  0 took her as needed erent occasions of which both entify any signs of anxiety or all interventions used.  R80 took her as needed efferent occasions. During the signs of anxiety, or all interventions were the use of the medication.  80 received 7 doses of the medication of why the medication.	F3	329	random residents per week for two months who receive PRN psychotr medications.  All staff have been re-educated to non-pharmacological interventions administration of anti-anxiety medicompliance at regularly scheduled meetings and make recommendatic continuance.  DON/designee is responsible.	prior to cations.		
	lorazepam and sign	R80 took 6 doses of anxiety, or						

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	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304	12/	50/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	attempted prior to the medication.  Review of R80's phon 01/20/16, the coindicated facility state behaviors, non-phase attempted and effectionate and effectionate of include behaviors interventions.  During interview on registered nurse (Rexpected to documentation and bethe as needed loraze there was no behave non-pharmacologic after reviewing R80.  When interviewed conursing (DON) states staff to document non-pharmacologic after reviewing R80.  When interviewed conursing (DON) states the document non-pharmacologic after reviewing R80.  When interviewed conursing (DON) states the document non-pharmacologic after reviewing R80.  When interviewed conursing (DON) states the document non-pharmacologic after reviewing R80.  When interviewed conursing (DON) states the document non-pharmacologic after reviewing R80.  When interviewed conursing (DON) states the document non-pharmacologic after reviewing R80.  When interviewed conursing (DON) states the document non-pharmacologic after reviewing R80.  When interviewed conursing (DON) states the document non-pharmacologic after reviewing R80.	al interventions were ne administration of the armacist drug regimen review insultant pharmacist (CP) iff needed to document rmacological approaches of tiveness for R80's as needed 14/16, the CP again indicated on R80's lorazepam needed and non-pharmacological interventions attempted in the region of all interventions attempted in the record.  In 12/07/16, the director of each it was important for facility on-pharmacological ehaviors in evaluate in the as needed lorazepam. There is use of this medication at the output of the director of each it was important for facility on-pharmacological ehaviors in evaluate in the end of the director of each it was important for facility on-pharmacological ehaviors in evaluate in the end of the director of end it was important for facility on-pharmacological ehaviors in evaluate in the end of the director of end it was important for facility on-pharmacological end of the end	F 3:	29		
F 353	behaviors symptom		F 3	53		1/17/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245438	B. WING			C <b>08/2016</b>	
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ( (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 353 SS=E	the appropriate conprovide nursing and resident safety and practicable physical well-being of each president assessment and considering the diagnoses of the fall accordance with the at §483.70(e). [As linked to Facility be implemented be (Phase 2)]  (a) Sufficient Staff. (a)(1) The facility most sufficient numbers of personnel on a 2 nursing care to all resident care plans.  (i) Except when was this section, license.	PLANS  rvices  ave sufficient nursing staff with inpetencies and skills sets to direlated services to assure attain or maintain the highest I, mental, and psychosocial resident, as determined by ints and individual plans of care in number, acuity and cility's resident population in a facility assessment required by Assessment, §483.70(e), will ginning November 28, 2017  aust provide services by of each of the following types 4-hour basis to provide esidents in accordance with increases; and ersonnel, including but not	F3				
	this section, the fac	waived under paragraph (e) of illity must designate a licensed charge nurse on each tour of					
	(a)(3) The facility m	ust ensure that licensed					

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION  G	COM	COMPLETED	
		245438	B. WING		C <b>12/08/2016</b>	
	PROVIDER OR SUPPLIER  NURSING AND REHA	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 353	nurses have the sp sets necessary to didentified through redescribed in the plate (a)(4) Providing car assessing, evaluati resident care plans needs. This REQUIREMED by:  Based on observative review, the facility for nursing staff to med 4 of 5 residents (R4 reviewed for activiti residents (R94) reviewed for activiti residents (R94) reviewed for activiti residents (R94) reviewed concerns wistaff in the facility.  Findings include:  ASSESSED RESIDMET:  See F282: The factorie was implement R49, R94 and R87) dependent on staff (ADLs).  See F312: The factorie factorie factorie was implement R49, R94 and R87) dependent on staff (ADLs).	ecific competencies and skill are for residents' needs, as esident assessments, and	F 35	F353- Sufficient 24 hour Nursin Per Care Plans  Talahi Nursing and Rehab Cent sufficient staff to meet the need residents.  Community meetings were held residents in regards to their need Meetings were held with staff to the most appropriate allocation  Review of call light response tindetermine trends or patterns.  Call light policy and procedure rand is current.  Information in regards to staffing procedures was communicated Resident Council.  Staffing information was shared meeting.  Staff re-educated to call light poprocedure.	er assures s of its  I with the eds. I determine of hours. These to The eviewed  Grant at staff	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED C	
		245438	B. WING				) 08/2016
	PROVIDER OR SUPPLIER	B CENTER		,			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 353	See F314: The faci assistance for toilet reduce the risk of p1 of 3 residents (RS pressure ulcers.  RESIDENT CONCI STAFFING:  R3's quarterly Mining 8/23/16, identified Frequired extensive  During interview on stated the facility lameet her needs timestaff were getting, "they had to rush threnough staff. R3 surine that same day with toileting quickly feel, "Upset and fur R3's Device Activity 12/8/16, identified to times:  On 11/25/16, at 11 for 43 minutes and On 11/27/16, at 11 for 18 minutes and On 11/28/16, at 75 for 16 minutes and On 11/30/16, at 11 for 15 minutes and	lity failed to provide timely ing and repositioning to ressure ulcer development for (4) identified at risk of  ERNS WITH LACK OF  mum Data Set (MDS) dated (A3 had intact cognition and (A3 h	F3	353	Education provided to direct care a regarding best practice for toileting bathing.  Audits of staff and resident intervie be conducted weekly in regards to and meeting resident's needs.  QAPI committee will review all audicompliance at regularly scheduled meetings and make recommendat continuance.  DON/designee, Human Resources responsible.	ews will staffing lits for ions for	

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION  NG		COMPLETED	
		245438	B. WING _		12	C 2/ <b>08/2016</b>
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 1717 UNIVERSITY DRIVE SOUTHEA SAINT CLOUD, MN 56304	ODE	700,2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 353	59 minutes and 20 - On 12/2/16, at 12 was on for 47 minu	7 a.m. the call light was on for seconds and; 35 a.m. the bathroom call light tes and 45 seconds.	F 35	53		
	R50 had intact cog	S dated 9/20/16, identified nition and required extensive activities of daily living (ADLs).				
	stated the facility no resident care. R50 the bathroom and, close" to having inc	12/5/16, at 2:10 p.m. R50 eeded more staff to completed stated he needs help to use at times, has come, "Pretty continence because there is assist him promptly.				
	12/8/16, identified t times: - On 11/30/16, at 2: for 23 minutes and - On 11/30/16, at 1: for 19 minutes and - On 12/7/16, at 3:0 16 minutes and 32	1:42 a.m. the call light was on 28 seconds; 13 a.m. the call light was on for seconds and; 3 a.m. the call light was on for				
		dated 11/15/16, identified R80 and required extensive Ls.				
	stated the facility w R80 stated she had assistance before a	12/5/16, at 2:30 p.m. R80 as not adequately staffed. It waited up to 30 minutes for and at times just has to, "Hang so she doesn't have				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245438	B. WING				) 08/2016
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 1717 UNIVERSITY DRIVE SOUTHEAS SAINT CLOUD, MN 56304			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUT TAG CROSS-REFERENCED TO THE APPRODE DEFICIENCY)		SHOULD	BE	(X5) COMPLETION DATE
F 353	12/8/16, identified t times: - On 11/30/16, at 6: for 22 minutes and - On 12/7/16, at 7:1 18 minutes and 41 - On 12/7/16, at 11: for 16 minutes and  R20's quarterly Min 10/6/16, identified F impairment.  During interview on stated the facility di provide timely assis stated he often has help, even after alrefurther, R20 stated before and it took s responded to help I STAFF CONCERN  During interview on assistant (NA)-A stashort staffed, "A corresidents become a completed in a time [residents] can sen resident baths are a are short staffed ar	ty Report dated 11/24/16 to he following call light response 52 p.m. the call light was on 7 seconds; 0 a.m. the call light was on for seconds and; 36 a.m. the call light was on 54 seconds.  Simum Data Set (MDS) dated R20 had moderate cognitive 12/5/16, at 6:11 p.m. R20 d not have enough staff to stance with his needs. R20 to wait up to 15 minutes for eady asking for assistance. If he had fallen in the hallway everal minutes before staffnim.  S WITH LACK OF STAFFING: 12/6/16, at 2:06 p.m. nursing ated the facility is typically uple times a week," and upset their cares are not ely manner adding, "They se it." NA-A stated the not always completed if they and staff run around the facility, their heads cut off," trying to	F3	353			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245438	B. WING				C <b>08/2016</b>
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIF 1717 UNIVERSITY DRIVE SOUTH SAINT CLOUD, MN 56304		<u> </u>	33/2313
(X4) ID PREFIX TAG			ID PREFI TAG	X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD BE S-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 353	stated the nursing days and being full main unit of the fact happening anymore get four aides." Not complete all of the like bathing, becaus NA-C stated the rewhen their baths a Further, NA-C state the concerns with I nurse managers as however, staff are During interview or stated the memory just two NA staff are the memory care used the memory care used the memory care used the memory care used the lack of sufficient [resident] not getting Further, NA-B state the lack of staff hamanagers and admitted the medication typically would only what we need," and result. TMA-A state the lack of the lack of state the lack of the lack only the lack of the	on 12/6/16, at 2:28 p.m. NA-C staff was, "Really short," some staffed with four aides on the sility was not consistently e adding, "We're lucky if we A-C stated it was difficult to assigned cares for residents, se of the lack of staffing. sidents, "Get really upset," and cares aren't completed. ed several staff had reported ack of sufficient staff to the administration of the facility, just told, "We're working on it."  In 12/6/16, at 2:45 p.m. NA-B care unit is typically staff with and a cart nurse. NA-B stated nit used to be staffed with gh, however, it was changed ation felt people were just, shown here." NA-B stated two mough to care for the residents ly, "You need to have three the behaviors we have." NA-B e was suffering as a result of the staffing adding, "They're and bathed," consistently. ed these concerns regarding did been, "Voiced strongly," to	F3	353			

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:			IPLE CONSTRUCTION  NG		COMPLETED		
		245438	B. WING _		12	C 2/ <b>08/2016</b>	
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP COL 1717 UNIVERSITY DRIVE SOUTHEAS SAINT CLOUD, MN 56304	DE .	700,2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S) CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 353	cares not being cornicated the memory staffed with three NA-D stated if they the day, then cares good." Further, NA motion and bathing they were short stated and get it, sometimed with the same staffing in residents had voice sufficient staffing in residents had particulated she had repostated she	ing about their baths and other impleted.  12/7/16, at 4:03 p.m. NA-D care unit was supposed to be IA staff and a cart nurse. did not have full staffing for suffer and were, "Not that IA-D stated residents' range of was not always completed if iffed adding, "Sometimes you es you can't."  on 12/7/16, at 4:47 p.m. urse (LPN)-C stated several ed concerns about a lack of the facility. LPN-C stated cularly complained about their impleted. Further, LPN-C orted concerns about a lack of tration.  12/8/16, at 9:52 a.m. the lirector (HRD) stated she was go the staffing assignments for cility used a chart and, "Just staff" to determine the staffing the HRD stated the typical ity was nine NA staff with three for the staff scheduled because baths	F 35	53			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245438	B. WING				08/ <b>2016</b>
_	PROVIDER OR SUPPLIER	B CENTER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 717 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)		PREFIX (EACH CORRECTIVE ACTION SHOUL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPORTION OF T	) BE	(X5) COMPLETION DATE
F 353	identified the follow facility census of 70  - NA for AM shift: 8  - NA for PM shift: 6  - NA for night shift: 6  - NA for night shift: 6  - NA for night shift: 6  - Nurse/TMA for AA  - Nurse/TMA for PA  - Nurse/TMA for night staff member (SM) staffed and baths, result. Further, SM concerns to them a facility adding these few times a week."  During an anonymous stated the staff end "Couple times a week."  During an anonymous stated the staff end "Couple times a week."  During answered slop provided consistent used to have pool shelpful because, "Athere," to help with report these concertold, "Try to do your they were unaware administration to has staffing in the facility of the factoric and each unit the staffing	or each shift. The chart ing desired staffing levels for a 0 (as it was during the survey):  8.6 - 8.9 (staff) 8.9 - 7.1 2.8 - 2.9  M shift: 3.5 - 3.6 M shift: 3.5 - 3.6 M shift: 2.0  Ous interview on 12/7/16, a  -A stated the facility was short bus all your get done," as a all-A stated residents had voiced about the lack of staff in the example complaints were heard, "A  Ous interview on 12/7/16, SM-B up working short staffed a, sek," which results in call lights were and cares not being thy. SM-B stated the facility staff available which was at least [you] had that person cares. SM-B stated the staff on to the nurses, but are just to best." Further, SM-B stated of anything being done by andle or address the lack of	F	353			

NAME OF PROVIDER OR SUPPLIER  Description:  245438  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  1717 UNIVERSITY DRIVE SOUTHEAST	3/2016
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	<i>5,</i> <b>20</b> 10
TALAHI NURSING AND REHAB CENTER  SAINT CLOUD, MN 56304	
(X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Continued From page 57 used between the main unit and memory care unit to complete baths and help on the floor. SM-C stated completing all assigned resident cares was "More difficult with that staffing ratio," and cares were suffering as a result. SM-C stated several resident and family concerns had been heard about cares not being completed in the recent months which was upsetting adding, "You just get frustrated."  When interviewed on 12/8/16, at 10:51 a.m. registered nurse (RN)-A stated she had heard several resident complaints about a lack of staffing, including a complaint as recently as the evening prior where a resident had to wait 17 minutes for assistance. RN-A stated 17 minutes was, "An extended time," to wait for assistance. Further, RN-A stated staff had reported several concerns with a lack of staffing to her which were forwarded to the staff coordinator and the director of nursing (DON).  On 12/8/16, at 2:15 p.m. the DON and administrator were interviewed about staffing in the facility. The facility typically used a guideline to determine staffing levels, however case load and acuity was also considered. The DON stated the staffing in the facility. "Was excellent," because the care was good adding no issues had been observed to warrant an increase in staffing levels, 'I know its good." The DON stated she typically speaks with staff during the morning rounds and was aware a, "Couple of concerns," had been brought forward about the lack of staffing levels in the facility. Further, the	

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245438	B. WING		C <b>12/08/2016</b>	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 12/	00/2010
TALAHI N	NURSING AND REHA	B CENTER		1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		D BE	(X5) COMPLETION DATE
F 353 F 364 SS=B	A facility Nursing Dedated 12/2010, ider adequate staffing for directed staff to use assign scheduled in and attempt to replate 483.60(d)(1)(2) NUTPALATABLE/PREFINALATABLE	djusted to reflect this.  epartment Staffing policy of the nursing floor," and of daily check in sheets to cursing staff to work groups, ace a call in if one occurs.  TRITIVE VALUE/APPEAR, ER TEMP  TRITIVE VALUE/APPEAR, OF TEMP	F3		ble. d on arlic	1/17/17
		of the Rosewood Unit evening 5/16, at 6:18 p.m. dietary aide		basis at which time any concerns brought to the attention of dietary.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245438	B. WING				08/ <b>2016</b>
	PROVIDER OR SUPPLIER	B CENTER		17	TREET ADDRESS, CITY, STATE, ZIP CODE 717 UNIVERSITY DRIVE SOUTHEAST AINT CLOUD, MN 56304	1 12/	30/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 364	(DA)-A wheeled a not begin serving the serving pan into the a loaf of sliced white exposed. DA-A begingle pieces of breathem on several difference of them on several difference of the piece of them on several resident of the sample tray was responded on the sample tray was responde	mobile cart into the kitchenette meal. DA-A placed a metallic steam table which contained be bread with only its top crusts gan to plate food by removing ad from the pan and placing ferent plates to be served. It downward as DA-A removed it only the top portion of crust on wisible yellowing coloring or erved plates with this bread on its along with pizza and salad. It discretized by the surveyor. The ted, but rather soft and limp, ow seasoning on the top it asted the bread and it	F3	364	QAPI committee will review all aud compliance at regularly scheduled meetings and make recommendati continuance.  Dietary Director is responsible.		

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NG	COMPLETED		
		245438	B. WING		12/0	8/2016
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO  (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 364 F 365 SS=D	on the bread and many of the bread and many of the preparation dated at the preparation of the pr	separately to, "Get more butter fore flavor."  sarlic Bread Recipe 2/7/16, directed cooking staff flargarine on each slice of  Residents' Rights and lated to Food Service undated, identified residents nourishing, palatable, and s that meet daily nutrition and IN FORM TO MEET S  In a form designed to meet  NT is not met as evidenced ion, interview and document ailed to comprehensively an appropriately textured diet on for 1 of 1 residents (R57) ewing a regular diet.	F3	F365 Food in Form to Meet Individual Needs  Talahi Nursing and Rehab Center prepares food in a formed design to individual needs.  R57 has been evaluated by the diefor mastication needs and the care	dual to meet etician e plan	1/17/17
	impairment, was ind no identified swallor During interview on stated she had rece concerned about it.	R57 had moderate cognitive dependent with eating and had wing disorders.  12/5/16, at 5:07 p.m. R57 ently lost a tooth and was R57 showed the surveyor her lible teeth missing on the		has been updated to include dietic recommendations.  R57 weight and intake are monitor regular basis.  Dietary Director has reviewed all consistency diets to ensure reside	red on a	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILDI		(X3) DATE SURVEY COMPLETED			
		245438	B. WING			12/0	)8/ <b>2016</b>
	PROVIDER OR SUPPLIER	B CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  1717 UNIVERSITY DRIVE SOUTHEAST  SAINT CLOUD, MN 56304				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 365	off at the gum line of stated it was more without all of her tecareful" with eating  During observation on 12/5/16, at 7:25 next to the dining reserved a hamburge only eaten approximand left the other hastated she couldn't too hard to chew, "I motioned with her hastated she couldn't too hard to chew, "I motioned with her hastated she couldn't too hard to chew, "I motioned with her hastated she couldn't too hard to chew, "I motioned with her hastated she couldn't too hard to chew, "I motioned with her hastated she couldn't too hard to chew, "Several probout a month prior.  R57's Patient Progression of the family did not we completed for R57, identified plan to act difficulty chewing her didntified R57 constexture restrictions Swallowing problem assessment. However, with the state of the s	difficult to chew her food lately eth adding she has, "To be now.  of the evening meal service p.m. R57 was standing up foom table. R57 had been or and bun, however R57 had nately 1/2 of the hamburger alf uneaten on the plate. R57 keep eating it because it was Because of the teeth," as she hand to her mouth.  disit note dated 11/11/16, been anxious and fixated lems" with teeth having fallen ess Note dated 10/4/16, was entist and identified R57 to a fractured off at the gumline," as she is having trouble nissing so many posterior note had a handwriting at the dated 10/27/16, and identified ant extensive dental work  The note lacked any dress R57's complaints of	F3	65	receiving diets to match their mast abilities. Concerns identified have in referred to appropriate discipline. In Dietician, MD, DDS.  Three audits per week for three we be conducted during meal times to residents whom may be having difficulting.  In-services were conducted with not staff to ensure they are identifying endorsing issues like difficulty chemanagement.  QAPI committee will review audits compliance at regularly scheduled meetings and make recommendat continuance.  DON/designee, Dietary Manger, Diresponsible	eeks will identify iculty ursing and wing to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION  NG		TE SURVEY MPLETED	
		245438	B. WING		12	C 2/ <b>08/2016</b>
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 1717 UNIVERSITY DRIVE SOUTHEA SAINT CLOUD, MN 56304	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 365	she had been seen "Several teeth fract chewing." The ass plan to address R5 chewing her food, ceasier for R57 to chewing interview on assistant (NA)-A stadiet at meals and he "Anywhere from 25 lately adding she had her food." Further, R57 had made any trouble chewing her was having any trouble chewing and the stated the repeated should have been for be addressed as R5 could potentially just trouble chewing, "Texpected nursing to When interviewed or registered nurse (R R57's weight and in concern with difficut that had to be addressed no assessme complaints of troub	by the dentist on 10/4/16 with, ured off [at] gumline, trouble dessment lacked any identified 7's complaints of difficulty of to modify her diet so it was new and eat her meal.  12/6/16, at 2:23 p.m. nursing ated R57 received a regular ad only been eating, to 75 percent" of her meals ad, "Never seen her finish all NA-A stated she was unaware complaints about having food.  In 12/6/16, at 3:29 p.m. athologist (SLP)-A stated red with R57, "In the last few ated she was unaware R57 ables chewing her food first I've heard of it." SLP-A concerns of trouble chewing orwarded to her so they could 57 was at a nutritional risk and at stop eating if she was having his is something I would have pass on."  In 12/7/16, at 11:45 a.m.  N)-B stated she had reviewed takes and did not feel R57's lty chewing was, "Something lessed," because her intakes er, RN-B stated there had not or plan to address R57's le with chewing her food ars to be chewing and	F3	65		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245438	B. WING			C <b>08/2016</b>	
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304	E	00/2010	
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 365	Continued From pa	nge 63	F 3	65			
F 371 SS=F	No further informat 483.60(i)(1)-(3) FO STORE/PREPARE		F 3	71		1/17/17	
		d from sources approved or story by federal, state or local					
		e food items obtained directly rs, subject to applicable State egulations.					
	facilities from using gardens, subject to	oes not prohibit or prevent produce grown in facility compliance with applicable pod-handling practices.					
		loes not preclude residents ods not procured by the facility.					
	(i)(2) - Store, prepa accordance with pr service safety.	re, distribute and serve food in ofessional standards for food					
	foods brought to re visitors to ensure s handling, and cons	regarding use and storage of sidents by family and other afe and sanitary storage, umption.  NT is not met as evidenced					
	Based on observareview, the facility f were discarded tim was maintained to illness for 66 of 70 food prepared in th	tion, interview, and document ailed to ensure left-over foods ely and cooking equipment reduce the risk of food borne residents who consumed the e kitchen. The facility also pired and opened nutritional		F371- Food Procedure/Storage Talahi Nursing and Rehab Cerstore food in accordance with standards for food service safe During survey all out dated food	nter does professional ety.		

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTR A. BUILDING				SURVEY PLETED
		245438	B. WING				) 08/2016
	PROVIDER OR SUPPLIER  NURSING AND REHA	B CENTER		1717 L	T ADDRESS, CITY, STATE, ZIP CODE JNIVERSITY DRIVE SOUTHEAST T CLOUD, MN 56304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 371	(R94, R93, R98, R9 whose nutritional simedication rooms.)  Findings include:  FACILITY KITCHE An tour of the facility 12/5/16, at 11:58 a. (DD). The following facility walk in cooleding acility walk in cooleding at 11/3/16. Two-quart contained at 11/21/16. Two-quart contained at 11/22/16. Two-quart contained at 11/22/16. Two-quart contained at 11/24/16. Two-gallon contained at 11/24/16. Two-gallon contained 11/24/16. Three-gallon contained 11/25/16. Three-gallon contained at 11/25/16.	not served to 8 of 8 residents 95, R92, R91, R90, R28) upplements were stored in N ty kitchen was completed on m. with the dietary director items were noted in the er:  er, of cherry topping dated er, 1/2 full, of cream style corn gallon bag dated 11/21/16 er 1/8 full of of mixed fruit er, 3/4 full, of fruit cocktail er of peaches, containing 2 cups, dated 11/24/16 her, full of sweet potatoes ner of bread stuffing dated ainer of turkey stock dated on 12/5/16 at 12:03 p.m., the on 12/5/16 at 12:03 p.m.	F3	All en the State of the State o	scarded.  The identified nonstick frying pansiscarded during the survey.  If opened unlabeled undated cansisure and jevity were discarded desurvey.  The interest are not allowed to be storated portions must be discarded in the interest are conducted by the consure no outdated food is in the known of the interest are not allowed to be storated and interest are conducted by the consure no outdated food is in the known of the interest are not outdated food in the interest in t	ored, decomposed in the second and neeting.	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED		
		245438	B. WING				08/ <b>2016</b>
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP 1717 UNIVERSITY DRIVE SOUTHI SAINT CLOUD, MN 56304			30/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ON SHOULD IE APPROPI	BE	(X5) COMPLETION DATE
F 371	shelf. The non-stice approximately 3/4 of frying pans, was miscratches which exfood items.  During an interview DD stated the non-cook up small quarnormally dispose the hesitant to do so reof equipment.  During a subseque p.m., the DD stated sweet potatoes were going to use the gravy stock for future stated both items with interview registered dietitian should be used in the facility leftover food items identified in the facility policy, undated 2009 indicated within 7 days or dis MEDICATION ROO	o non-stick frying pans on a k coating material, over of the surface area of both sising and had multiple posing the non-stick surface to on 12/5/16 at 12:03 p.m. the stick fry pans were used to attities of food. She would be scuffed pans, but was lated to a delay in replacement on tinterview on 12/7/16, at 1:08 of the left-over turkey stock and the from Thanksgiving. They have items to make soup or the resident meals. The DD would make approximately servings of soup for the days or less because of k of food-borne illness."  Or RD identified they had to use in three days or less, the items allity walk in cooler were there as being opened.  Stated, titled "Food Storage," ed "Leftover food is used carded."	F3	71			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		COM	E SURVEY IPLETED
		245438	B. WING _			C <b>08/2016</b>
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304		30.2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 371	and undated/unlabe shake) for R93, R9 (nutritional shake) fo opened date.  During observation the North medication opened unlabeled/tresponsored unlabeled/tresp	on room there were two opened eled cans of Ensure (nutritional 6, R26 and one can of Jevity or R94, initialed, but had no on 12/05/16, at 6:57 p.m. of on storage room an one undated can of Ensure for on 12/05/16, at 6:57 p.m. N)-A examined the opened ity in the North and West ators and stated Ensure/Jevity 14 hours after it is opened. She wing" how long the een in the refrigerator. It is dall open supplements sidents initials and date they went them from being used in date.  12/06/16, at 8:49 a.m. the stated all supplements should hen opened as they expired	F 37			
F 387 SS=D	483.30(c)(1)(2) FRI PHYSICIAN VISIT	EQUENCY & TIMELINESS OF	F 38	7		1/17/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		245438	B. WING		12/08	/2016
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIO DEFICIENCY)	BE C	(X5) OMPLETION DATE
F 387	least once every 30 admission, and at least once every 30 admission, and at least occurs not later that visit was required. This REQUIREMED by:  Based on interview facility failed to ensprovided at least or 90 days after admission who were newly ad Findings include:  R31's admission m 8/26/16, indicated r R31's hospital discludes	nysician Visits  nust be seen by a physician at a days for the first 90 days after east once every 60 thereafter.  is considered timely if it in 10 days after the date the extraction of the second of the every 30 days for the first every 30 days for the first exist of the facility.  In immum data set (MDS), dated no cognitive impairment.  In arge report, dated 8/19/16,	F 38'	F387- Frequency/Timelines of Phys Visits  Talahi Nursing Rehab Center assure residents are seen in a timely mannaccordance with rules and regulation R31 has been seen by a physician a followed by the physician on a regulations.  Talahi Nursing and Rehab Center has	es er in ns. and is ar	
	indicated she had be following a hospital diagnosis list, dated admission diagnose along with a history (kidney damage), hobstructive pulmon A review of physicial notes identified the - On 8/31/16, R31 rassessed by her fronte indicated that	deen admitted to the facility I stay related to leg pain. R31's d 12/7/16, identified an es of cellulitis (skin infection) of diabetes with nephropathy eart failure, and chronic ary disease.		contracted with new Medical Director begin 1/1/2017 who is committed to seeing our residents in a timely man A calendar has been established to timely physician services for all new admissions, it is maintained daily by Health Unit Coordinator and reviewed weekly by the DON.  QAPI committee will review audits for compliance at regularly scheduled meetings and make recommendation continuance.	or to nner. track the ed	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING				E SURVEY PLETED	
		245438	B. WING				C <b>08/2016</b>
	PROVIDER OR SUPPLIER	B CENTER		17	TREET ADDRESS, CITY, STATE, ZIP CODE 717 UNIVERSITY DRIVE SOUTHEAST AINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 387	long-term placemen need to transfer can need to transfer can - On 10/17/16, 47 divisit, R31 had an apwith a different physical buring the appointr completed, but the accept her as a pat occur within 30 day 8/31/16 initial physical buring interview on registered nurse (R difficult to find R31 primary physician with RN-A stated the sitt primary physician with the facility policy. R continuity in physicial contact if there were buring interview on stated she felt "Abate experience and "Didown" referring to reconsistent physicial buring interview on of nursing (DON) status in the facility However, the DON care for that long.	ations" and that "Given ht in skilled nursing facility will re."  lays after her last physician oppointment to establish care sician outside the facility. In ent, an assessment was physician later declined to ient. The physician visit did not s, but 47 days since her cian visit.  12/7/16, at 12:27 p.m.  IN)-A stated it had been a new physician, when her wouldn't follow her anymore. Luation was rare that the would stop seeing a patient he facility, and was unaware of N-A stated (R31) needed ans so staff knew who to be medical problems.  12/7/16, at 3:50 p.m. R31 andoned and frustrated" by the dn't like the way things went not being followed by a	F3	887	DON/designee, Social Service, Admissions, HUC are responsible.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
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	245438	B. WING		12/	08/2016
NAME OF PROVIDER OR SUPPLIER  TALAHI NURSING AND REHAB	3 CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304		
PREFIX (EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO  (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
nursing home. It was R31's primary physic her until she had been physician, but indicated responsible for overstates Bill of Rights, facility would seek at "Assure provision of care and treatment."  F 425 SS=E ACCURATE PROCE  (a) Procedures. A fact pharmaceutical serve that assure the accurdispensing, and admitiologicals) to meet to be Service Consultated employ or obtain the pharmacist whore the serve that the pharmacist whore the serve that the pharmacist whore the pharmacist whore the serve that the pharmacist whore the pharmacist whore the serve that assure the accurdispensing, and admition biologicals) to meet the service of the service of the service of the expired facility failed to ensure the service of the expired facility failed to ensure the service of the expired facility failed to ensure the service of the expired facility failed to ensure the service of the expired facility failed to ensure the service of the expired facility failed to ensure the service of the expired facility failed to ensure the service of the expired facility failed to ensure the service of the expired facility failed to ensure the service of the expired facility failed to ensure the service of the service of the expired facility failed to ensure the service of the service of the expired facility failed to ensure the service of the ser	s physician while at the sthe responsibility of the cian to continue to care for en accepted under a new sted he was ultimately seeing R31's care.  Combined Federal and dated 11/28/16, directed the lternate physician services to appropriate and adequate  RMACEUTICAL SVC - EDURES, RPH	F 4	87	meet	1/17/17

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245438	B. WING			12/0	)8/ <b>2016</b>	
	PROVIDER OR SUPPLIER	B CENTER		17	REET ADDRESS, CITY, STATE, ZIP CODE 17 UNIVERSITY DRIVE SOUTHEAST AINT CLOUD, MN 56304	12/	JO/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 425	storage room was of (RN)-D. The West is contained an open of Purified Protein Delused to test for expexpiration date of 1 RN-D stated the tult for residents and fastated expired TB sadministered after the could cause an "inate of the could cause an	CULIN SOLUTION 10 p.m. the West medication observed with registered nurse medication storage refrigerator of package of Tuberculin rivative (TB) (a medication osure to Tuberculosis) with an 0/10/16, written on the vial. Derculin solution was available cility staff. Further, RN-D olution should not be he expiration date because it accurate result."  umentation titled, "Baseline arsing home and boarding given an expired TB test (lot in 12/1/16, 21 days after it in iven expired TB solution (lot in 11/22/16, 12 days after it is as administered TB test (lot in 11/21/16, 11 days after it in 11/21/16, 11 d	F 4	25	The PPD was all relocated to one refrigerator at the north med room.  Audits are conducted weekly by the DON/designee to assure all opened PPD is dated.  R94 mybetriq was discontinued.  DON/designee is responsible to reveach MAR on admission to assure method of administration is noted.  QAPI committee will review audits compliance at regularly scheduled meetings and make recommendatic continuance.  DON/designee is responsible.	view proper		

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
		245438	B. WING			C <b>12/08/2016</b>		
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP C 1717 UNIVERSITY DRIVE SOUTHEA SAINT CLOUD, MN 56304	ODE	12/00/2010		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI  (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE		
F 425	During interview on director of nursing (solution should hav opened for thirty da effectiveness could. A facility policy on ewas requested, but survey.  MANUFACTURE GR94's Individual Re 12/1/16, indicated Fand aspiration and mouth (NPO). R94 sheet indicated R94 the mouth.  R94's Dismissal Sudated 12/1/16, indicated 12/1/16, indicated foliated in abdomina nutrition, fluids and/into the stomach, be esophagus) tube preceive myrbetriq (roveractive bladder) release (designed tover a extended pemorning.  A speech therapy (\$12/02/16, indicated on command and hoted.	12/06/16, at 8:49 a.m. (DON) stated the tuberculin e been discarded after being ys because the medications be decreased.  expiration dates for TB solution was not provided during the discent Care Plan dated R94 was at risk for choking was to receive nothing by 's Admission Record face had a malignant neoplasm of a many from Mayo Clinic cated R94 had dysphagia	F4	25				

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED C		
		245438	B. WING				) 08/2016
	PROVIDER OR SUPPLIER			17	REET ADDRESS, CITY, STATE, ZIP CODE 17 UNIVERSITY DRIVE SOUTHEAST AINT CLOUD, MN 56304		,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 425	medications. LPN medications except stated the medication and could not be cigiven by mouth. Ladministered R94's myrbetriq, via pegt would not be able she was uncertain. During interview 12 stated she spoke with discontinued myrbetrial and received the madmission, but was administered this received the madmission, but was administered this received the nurses swith R94's physicial buring a subsequence of stated the nurses swith R94's physicial During a subsequence of security policy was medications according to the security policy was medications according to the security policy was medications and A Patient Information A Patient	urse (LPN)- D set up R94's -A crushed all of R94's -t for THE myrbetriq. LPN-D ion was "sustained released" rushed, and was ordered to be PN-D entered R94's room and s medications, except tube. LPN-A then stated she to give R94 myrbetriq because if R94 could swallow the pill.  2/07/16, at 1:00 p.m. LPN-D with R94's physician who etriq. LPN-D also stated R94 hyrbetriq five times since s uncertain how the staff nedication to R94.  2/08/16, at 9:15 a.m. the (DON) stated the staff must he myrbetriq by crushing it, it via the peg tube. The DON should have clarified this order an.  ent interview on 12/08/16, at tated she had given R94 ing it and giving it via R94's  s requested on giving ding to manufacture was not received.  on from the manufacture S, Inc. revised August 2016, "You should take Mybetriq with the tablet whole. Do not crush	F 4	25			

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		245438	B. WING			12/	08/2016
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE  1717 UNIVERSITY DRIVE SOUTHEAST		
ΤΔΙ ΔΗΙ Ι	NURSING AND REHA	B CENTER					
IALAIII.	NOTIONIO AND ILLIA	D OLIVIEIV			SAINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431 SS=E	LABEL/STORE DR  The facility must prodrugs and biological them under an agre §483.70(g) of this punlicensed personnel aw permits, but on supervision of a lice (a) Procedures. A supharmaceutical ser that assure the accessing dispensing, and additional to biologicals) to meet (b) Service Consult employ or obtain the pharmacist who  (2) Establishes a syndisposition of all condetail to enable and (3) Determines that that an account of a maintained and permits and biological labeled in accordant professional principal appropriate accessinstructions, and the applicable.	facility must provide vices (including procedures urate acquiring, receiving, ministering of all drugs and the needs of each resident.  ation. The facility must e services of a licensed vicensed vicensed vicensed vicensed vicensed in controlled drugs in sufficient accurate reconciliation; and all controlled drugs is riodically reconciled.  gs and Biologicals. The facility must be not with currently accepted oles, and include the ory and cautionary e expiration date when	F	431	, , , , , , , , , , , , , , , , , , ,		1/17/17
		is and Biologicals.  with State and Federal laws,  re all drugs and biologicals in					

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245438	B. WING		C <b>12/08/2016</b>		
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304	12/00/2010	<u>,                                    </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPOLICIENCY)	D BE COMPLÉ	TION	
F 431	controls, and perminave access to the  (2) The facility mus permanently affixed controlled drugs list Comprehensive Drugs Comprehensive Drugs Control Act of 1976 abuse, except when package drug distriquantity stored is more readily detected. This REQUIREMED by:  Based on observative review, the facility fuberculin solution and expired. Novoli Lantus insulin (medicals were removed not administered to who used insulin with failed to ensure tub for resident and state This had potential to the R98 and R95) who removed include:  INSULIN  R2's quarterly Minimal 10/28/16, identified mellitus (metabolic)	Ints under proper temperature tonly authorized personnel to keys.  It provide separately locked, decompartments for storage of ted in Schedule II of the ug Abuse Prevention and and other drugs subject to in the facility uses single unit bution systems in which the tinimal and a missing dose can like the tinimal and a missing dose can like the tinimal and a missing dose can like to ensure insulin and cottles were dated when open, in, Novolog, Levemir, and dication used to treat diabetes) I from medication carts and 2 of 11 residents (R2, R31) if thin the facility. Further, facility erculin solution was available if use and were not expired. The tinity of the expired solution.  In the state of the expired solution.	F 431	F431- Drug Records, Label/Store Talahi Nursing and Rehab Center provide pharmaceutical service to the needs of each resident.  R2 and R31 insulin were discarde time of the survey.  All insulin is dated when opened.  Staff have been re-educated to the procedure of opening and dating in Med carts will be audited two time week for three weeks to ensure al that is opened is dated.  All opened and undated TB PPD of were discarded during survey.	does meet d at ensulin. s a I insulin		
	Review of R2's und	s and may require insulin).  ated physician's orders ed Novolog (insulin used for		The PPD was all relocated to one refrigerator at the north med room			

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		245438	B. WING				C 0 <b>8/2016</b>
	PROVIDER OR SUPPLIER	B CENTER	l	1	TREET ADDRESS, CITY, STATE, ZIP CODE 717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304	1 12/0	30/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	morning and 56 un quarterly Minimum 10/22/16, identified mellitus (metabolic blood glucose leve R31's quarterly Mir 11/19/16, identified mellitus (metabolic blood glucose leve Review of R31's ur identified R31 rece diabetes) 5 units state a day with meals at carbohydrate four the During observation 12/06/16, at 11:57 at delivery date from and R31's Levemir 10/22/16.  When interviewed nursing assistant (I observe an expiration insulin. Further, Nainsulin's for these reart which she (NA) During interview 12 nurse (RN)-A state opened it should be date as it was only been opened.  A review of a the melli Lilly instructs to	subcutaneous (SQ) in the its in the evening. R69's Data Set (MDS) dated R69 had type two diabetes disease causing increase is and may require insulin).  Simum Data Set (MDS) dated R31 had type two diabetes disease causing increase is and may require insulin).  Simum Data Set (MDS) dated R31 had type two diabetes disease causing increase is and may require insulin).  Sindated physician's orders ived Novolog (insulin used for abcutaneous (SQ) three times and 4 units per each imes a day.  Of the medication cart a.m. R2's Humulin insulin had an the pharmacy on 10/25/16 insulin had a delivery date of the insu	F 4	31	Audits are conducted weekly the DON/designee to assure all opener PPD is dated.  R94 Mybetiq was discontinued.  DON/designee is responsible to releach MAR on admission to assure method of administration in noted.  QAPI will review audits for complia regularly scheduled meetings and recommendations for continuance.  DON/designee is responsible.	view proper nce at make	

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			TE SURVEY MPLETED
		245438	B. WING _		12	C 2/ <b>08/2016</b>
	PROVIDER OR SUPPLIER	AB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 431	review of manufaci Nordisk stated Lev days after it is open TUBERCULIN:  On 12/05/16, at 05 storage room was (RN)-D. The West contained an open Purified Protein Deused to test for expexpiration date of 1 RN-D stated the tufor residents and fastated expired TB administered after could cause an "inautomatic Upon review of dot TB Screening for presidents" R94 was number 772984) of expired. R93 was considered and R98 with manufacture and R98 with case of Tuberc with date of when the stated the tubercul resident use, but we will resident use.	turers instructions from Norvo emir insulin is expired after 42 ned.  :10 p.m. the West medication observed with registered nurse medication storage refrigerator ed package of Tuberculin erivative (TB) (a medication posure to Tuberculosis) with an 10/10/16, written on the vial. berculin solution was available acility staff. Further, RN-D solution should not be the expiration date because it	F 4:	31		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245438	B. WING			C / <b>08/2016</b>	
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304	DE	30/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE	
F 431	knowing when the swas not dated.  A facility policy on 6	age 77 pened but they had not way of solution was opened since it expiration dates for TB solution was not provided during the	F 4	31			
F 441 SS=F	survey.  A facility policy titled and Storage" dated is to be dated on the Further, the policy carts for outdated r 483.80(a)(1)(2)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)	d,"Medication Administration d 3/24/2016, identified, "Insuling vial or tube when opened." stated to check medication medications weekly. e)(f) INFECTION CONTROL,	F 4	41		1/17/17	
	The facility must es and control prograr a minimum, the foll  (1) A system for pre investigating, and communicable disc volunteers, visitors providing services arrangement based conducted accordin accepted national simplementation is F  (2) Written standar for the program, whimited to:  (i) A system of surv	stablish an infection prevention in (IPCP) that must include, at lowing elements: eventing, identifying, reporting, controlling infections and eases for all residents, staff, and other individuals under a contractual dupon the facility assessmenting to §483.70(e) and following standards (facility assessment					

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245438	B. WING				C 08/2016	
NAME OF F	PROVIDER OR SUPPLIER	7 77		S	TREET ADDRESS, CITY, STATE, ZIP CODE	12/	00/2010	
ΤΔΙ ΔΗΙΙ	NURSING AND REHA	R CENTER	1717 UNIVERSITY DRIVE SOUTHEAST					
IALAIIII	TOTISING AND TILLIA	BOLNIEN		S	SAINT CLOUD, MN 56304			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 441	facility;	age 78 read to other persons in the nom possible incidents of	F 4	41				
		ease or infections should be						
		ansmission-based precautions event spread of infections;						
	(iv) When and how resident; including I	isolation should be used for a but not limited to:						
	<ul> <li>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</li> <li>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</li> </ul>							
	must prohibit emplo disease or infected	ces under which the facility byees with a communicable skin lesions from direct hts or their food, if direct t the disease; and						
		ne procedures to be followed direct resident contact.						
		cording incidents identified PCP and the corrective e facility.						
		nel must handle, store, port linens so as to prevent the						
	(f) Annual review.	The facility will conduct an						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245438	B. WING			12/0	)8/2016
	PROVIDER OR SUPPLIER			17	TREET ADDRESS, CITY, STATE, ZIP CODE 717 UNIVERSITY DRIVE SOUTHEAST AINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	program, as necess This REQUIREME by: Based on interview facility failed to imprintection control program, trending a infections to prever This had potential and visitors to the failed to ensure stange with appropriate (R39) observed the failed the	is IPCP and update their is sary.  INT is not met as evidenced in and document review, the plement a comprehensive ogram to include consistent and analysis of illnesses and int potential spread to others. It is affect all 70 residents, staff facility. In addition, the facility aff completed a dressing priate hand hygiene for 1 of 1 is served during wound cares.  In a different tabbed sections specific month of infection. The following information was a feet the following information in the completed and in a dental in a and a "Rash." The report of symptom onset or resolution, ganisms, or if the infection was incompleted in the completed in the completed and in the complete in the completed and in a symptom onset or resolution, ganisms, or if the infection was incompleted in the completed in the	F 4	.41	F441- Infection Control  Talahi Nursing and Rehab Center maintains an infection prevention program.  Infection control policies and proced have been updated, and are current Infection control tracking forms for residents and employees has been created to include all pertinent data regarding the infection.  Infection control committee meets was to analyze any trending in the data collected for infections.  QAPI meets monthly and reviews information collected by the infection control committee.  The clean dressing change policy has been reviewed and is current. Nurse have been re-educated on the clear dressing change technique.  Random audits will be conducted or	veekly  as es n	
	acquired.  A single Employee	Call-In Report dated 9/1/16, byee called in ill with symptoms [and] a fever."			whom complete dressing changes tensure proper technique is followed  QAPI committee will review audits for compliance at regularly scheduled meetings and make recommendation continuance.	or	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ,		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245438	B. WING				08/ <b>2016</b>
	PROVIDER OR SUPPLIER  NURSING AND REHA	B CENTER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	Services reports daidentified different of specimens. The refresidents had urine same bacteria, how on the date of sympinfection was deternin-house acquired.  The collected data analysis of the infect determine the caus had potential to, or  OCTOBER 2016:  An Order Listing Resix residents had remonth for different chronic pain syndrosevere sepsis. The symptom onset or room numbers, or it to be community or  An undated Infection resident had an infection to the community or spacing to place a computer of infection had spacing to place a computer of infection the symptoms which had symptoms which	Centracare Laboratory ted 9/1/16, through 9/30/16, cultures of collected ports identified three different samples cultured with the rever lacked any information of on onset, resolution, or if the mined to be community or  lacked any trending or ctions in the facility to e of each infection or if they were spreading in the facility.  export dated 12/5/16, identified deceived antibiotics during the diagnosis which included me, pneumonia, yeast, and export lacked any dates of esolve, organism cultures, if the infection was determined in-house acquired.  In Report Form identified a ection noted to begin on I her name, sex and room had spacing to identify what d occurred including additional checkmark in corresponding er, all of these fields were left was entered to identify what a resident had or any	F 4	.41	DON/designee is responsible.		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION  IG		ATE SURVEY DMPLETED
		245438	B. WING _		1	C <b>2/08/2016</b>
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304		2/00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 441	different resident wadmission; however information. The reblank and no data type of infection the symptoms which have the collected data analysis of the infedetermine the cause had potential to, or NOVEMBER 2016  An Order Listing Renine residents had month for different urinary tract infection, "Rash." The repsymptom onset or organism cultures, determined to be cacquired.  The data lacked ar infections in the face ach infection or if spreading in the face and the identified module of the ide	with their name, unit and date of er lacked any further emainder of the form was left was entered to identify what e resident had or any ad developed.  lacked any trending or ctions in the facility to se of each infection or if they were spreading in the facility.  Export dated 12/5/16, identified received antibiotics during the diagnosis which included on, bronchitis, pneumonia, and port lacked any dates of resolution, room numbers, or if the infection was ommunity or in-house  my trending or analysis of the cility to determine the cause of they had potential to, or were cility.  er information provided for any	F 44			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	COM	E SURVEY PLETED
		245438	B. WING				08/ <b>2016</b>
	PROVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, STATE, ZIP CODE 717 UNIVERSITY DRIVE SOUTHEAST FAINT CLOUD, MN 56304	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 441	control program latrending or analysi "We have to come "Have better tracki facility]." Further, taware the program components for the During interview or administrator state for infections durin throughout the werprocesses for track of infection are being pattern."  A facility Infection 2/16/16, identified "Help prevent the of disease and infection," and hat investigation, and infectious disease summaries of the land analyzed by the with findings being changes in practice.  HAND HYGIENE R39's admission M7/12/16, identified a diagnosis of contright above the kne R39's significant of the land analyse of contright above the kne R39's significant of the land analyse of the land ana	the DON stated the infection cked consistent monitoring, so of the collected data adding, to a better system," and, ng of that [infections in the he DON stated she had been a was lacking these e past couple weeks.  In 12/8/16, at 10:32 a.m. the d staff were, "Always watching" g their regular meetings ek, however do not start any king or trending unless patterns ng noted, "I look for the  Control Program policy dated an objective which included, development and transmission ection." The policy identified of the facility program which ance based on systemic data wing, "A system for detection, control of outbreaks of"  Further, the policy identified infections were to be compiled e infection control committee, communicated to determine if e or procedures were required.  Ininimum Data Set (MDS) dated R39 was cognitively intact with gestive heart failure and an ee amputation. On 10/17/16, hange in status MDS identified geable pressure ulcer on R39's	F 4	141			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG		TE SURVEY MPLETED
		245438	B. WING _		12	2/08/2016
	PROVIDER OR SUPPLIER  NURSING AND REHA	B CENTER		STREET ADDRESS, CITY, STATE, ZIP C 1717 UNIVERSITY DRIVE SOUTHEA SAINT CLOUD, MN 56304	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 441	physician order on change to left heel: saline, dry. Cover we Change daily and of During observation practical nurse (LP gloves. With her classified bandage from the trash. Without gloves, LPN-A-A of accidentally dropped the bandage off the her (LPN-A's) pock dressing without fir With her same soil R39's left heel pressing without fir with her same soil R39's left heel, R39'the soiled bed liner she placed a new of heel and then removed.	lministration record identified a 11/04/16, for "Dressing Clean open area with normal with Melgisorb dressing. on an as needed basis." on 12/07/16, licensed N)-A donned a set of clean ean gloves, LPN-A took off the m R39's left heel and threw it at first removing her soiled otained a new bandage and ed it on the floor. She grabbed e floor and obtained a pen from set to mark a date on the st removing her soiled gloves. ed gloves, LPN-A irrigated source ulcer. After irrigating e placed his clean heel unto h. With her same soiled gloves, clean dressing over R39's left oved her soiled gloves. LPN-A wash her hands in R39's	F 44			
	licensed practical recontaminated the pheel after she (LPN dug in her pocket vistated R39's heel sibed after being irrig R39's risk for an init is important to do when working with was a higher risk of and an increased repuring interview or assistant director of	on 12/07/16, at 7:33 a.m. nurse (LPN)-A stated she pressure ulcer on R39's left VI-A) touched the ground and with her gloved hands. LPN-A should have not touched the gated because it increased fection. Further, LPN-A stated on on a clean set of gloves pressure ulcers because there if "contaminating" the area lisk of infection.  1 12/07/16, at 11:18 a.m. the if nursing (ADON)-A stated is could contaminate the area				

STATEMENT OF DEF		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED
		245438	B. WING				08/ <b>2016</b>
NAME OF PROVIDE		B CENTER		17	TREET ADDRESS, CITY, STATE, ZIP CODE 717 UNIVERSITY DRIVE SOUTHEAST AINT CLOUD, MN 56304	12/0	50/2010
	EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
and i press  Where direct to we treat to the server	n interviewed of tor of nursing sear soiled glove ment as it coule pressure ulce licy regarding hot provided du 70(h)(1)(2) RE IICAL DIRECT dedical director he facility muse as medical director he medical director he medical director to address nuity for 1 of 1 ve medical calician.	risk of infection to R39's his left heel.  on 12/07/16, at 11:43 a.m. the stated it was "inappropriate" es during pressure ulcer d increase the risk of infection er on R39's left heel.  nand hygiene was requested, ring the survey.  SPONSIBILITIES OF OR  t designate a physician to	F 4		F501- Responsibilities of the Medic Director  Talahi Nursing and Rehab Center a resident are seen in a timely manner accordance with rules and regulation R31 has been seen by physician are followed by the physician on a regulasis.  Talahi Nursing and Rehab Center has been seen by physician or a regulation of the physician of th	essures er in ons. nd is lar	1/17/17

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION		E SURVEY PLETED
		245438	B. WING			12/0	) 0 <b>8/2016</b>
	PROVIDER OR SUPPLIER			S 1	TREET ADDRESS, CITY, STATE, ZIP CODE 717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304	12/0	J8/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 501	indicated she had be following a hospital also indicated a following a hospital also indicated a following primary physician a R31's diagnosis list identified an admissinfection) along with nephropathy (kidne chronic obstructive). A review of physicial notes identified the On 8/31/16, R31 reassessed by her pring The note indicated visits due to her "Acconditions with multi" (Given long-term placility will need to the Contacting the faconcerning R31's neare." On 10/17/16, 47 da R31 had an appoint different physician, assessed R31. The becontacting the faconcerning R31's neare." On 10/24/16, as a patient recommerconder, and offered facility.  On 11/3/16, 76 days an appointment with R31, the PA-A also patient due to her contacting the contacting the facility.	narge report, dated 8/19/16, een admitted to the facility stay related to leg pain, which ow up appointment with her to the facility in one week.  If dated 12/7/16, further sion diagnosis of cellulitis (skin a history of diabetes with y damage), heart failure, and pulmonary disease.  In and physician assistant (PA) following:  In acceived a visit and was mary medical doctor (MD-B). That R31 needed monthly divanced multiple comorbid tiple medications" and that accement in skilled nursing	F 5	601	contracted with a new Medical Dire begin 1/1/2017 who is committed to seeing our residents in a timely made A calendar has been established to timely physician services for all new admissions, it si maintained daily be HUC and reviewed weekly by the EQAPI committee will review audits compliance at regularly scheduled meetings and make recommendatic continuance.  DON/designee, Social Services, Admissions, HUC are responsible.	nner. track v y the OON.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION  NG		DATE SURVEY COMPLETED
		245438	B. WING _			C <b>12/08/2016</b>
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODI 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304		12/00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ( (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 501	R31 had an appoin facility who comple became her primar A facility Progress I the facility had requirector (MD)-A to because they were R31. A Progress Nother facility Medical follow R31 as a pat R31's medical recomplete Medical Director-A of R31 in September within 30 days of head There was also no Director-A had bee establish care with During interview on stated she felt "Abar experience and "Director-A had bee establish care with During interview on stated she felt "Abar experience and "Director-A had bee establish care with During interview on stated she felt "Abar experience and "Director-A had bee establish care with During interview on stated she wasn't follow here ouldn't see her, she was "Just hoping a During interview on stated he wasn't abdue to her younger hadn't seen R31 in	lys after she was admitted, tment with a MD-D outside the ted an assessment of R31 and by physician.  Note, dated 9/26/16, indicated lested the facility's Medical follow R31 starting 9/27/16, unable to find a physician for lote, dated 10/26/16, indicated Director-A had declined to	F 50	01		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION  NG		ATE SURVEY OMPLETED
		245438	B. WING		1	C <b>2/08/2016</b>
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304		2/00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ( (EACH CORRECTIVE ACTION SHOOT CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 501	care twice. The MD facility to contact his stating he was ultimed During interview on of nursing (DON) station of nursing	ge 87  The property of the pro	F 5	01		

JENTEKS I	OR MEDICARE & MEDICAID SERVICES			. A FUR
STATEMENT C	OF ISOLATED DEFICIENCIES WHICH CAUSE	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY
NO HARM WIT	TH ONLY A POTENTIAL FOR MINIMAL HARM		A. BUILDING:	COMPLETE:
FOR SNFs AND	) NFs	245438	B. WING	12/8/2016
NAME OF PRO	OVIDER OR SUPPLIER	STREET ADDRESS, C	ITY, STATE, ZIP CODE	
FALAHI NU	URSING AND REHAB CENTER	1717 UNIVERSIT SAINT CLOUD,	Y DRIVE SOUTHEAST MN	
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCE	IES		
F 156	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NO	TICE OF RIGHTS, R	ULES, SERVICES, CHARGES	
	(d)(3) The facility must ensure that each recontacting the physician and other primary			
	§483.10(g) Information and Communicati (1) The resident has the right to be inform resident conduct and responsibilities durin	ed of his or her rights		
	(g)(4) The resident has the right to receive in a format and a language he or she under	• .	ng spoken) and in writing (including Braill	e)
	(i) Required notices as specified in this sedescription of legal rights which includes	-	t furnish to each resident a written	
	(A) A description of the manner of protect	ting personal funds, ur	nder paragraph (f)(10) of this section;	
	(B) A description of the requirements and right to request an assessment of resources		shing eligibility for Medicaid, including the of the Social Security Act.	e
	and informational agencies, resident advo-	cacy groups such as the sman program, the pro- sdiction in long-term ca		ve
	_	sing facility regulation resident property in the	s, including but not limited to resident abuse facility, non-compliance with the advance	
		g-Term Care Ombudsi mended 2016 (42 U.S.0 ate, and as established (42 U.S.C. 15001 et s	under the Developmental Disabilities eq.)	
	(iii) Information regarding Medicare and I [§483.10(g)(4)(iii) will be implemented be		<del>-</del>	

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

The above isolated deficiencies pose no actual harm to the residents

Event ID: J6VE11 If continuation sheet 1 of 4

	ISOLATED DEFICIENCIES WHICH CAUSE	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY			
	I ONLY A POTENTIAL FOR MINIMAL HARM	TROVIDER #	A. BUILDING:	COMPLETE:			
FOR SNFs AND N		245438	B. WING	12/8/2016			
	IDER OR SUPPLIER RSING AND REHAB CENTER	1717 UNIVERSIT	STREET ADDRESS, CITY, STATE, ZIP CODE  1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN				
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIEN	CIES					
F 156	(B)(iii) of the Older Americans Act); or of [§483.10(g)(4)(iv) will be implemented by the content of the Medicaid (§483.10(g)(4)(v) will be implemented by the content of the Medicaid (§483.10(g)(4)(v) will be implemented by the content of the Medicaid (§483.10(g)(4)(v) will be implemented by the content of the Medicaid (§10) and contact information violation of state or federal nursing facility exploitation, misappropriation of resident requirements and requests for information (g)(5). The facility must post, in a form a representatives:  (i) A list of names, addresses (mailing and advocacy groups, such as the State Survestate law provides for jurisdiction in long Ombudsman program, the protection and and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file violation of state or federal nursing facility exploitation, misappropriation of resident directives requirements (42 CFR part 48 community).  (g)(13) The facility must display in the for admission, oral and written information and how to receive refunds for previous (g)(16) The facility must provide a notice during the resident's stay.	other No Wrong Door P Deginning November 28 I Fraud Control Unit; ar eginning November 28 for filing grievances or ity regulations, includin it property in the facility in regarding returning to and manner accessible an id email), and telephone by Agency, the State lice geterm care facilities, the id advocacy network, hold is a complaint with the S ity regulation, including it property in the facility is subpart I) and request acility written information in about how to apply it payments covered by su is of rights and services both orally and in writin lations governing reside	d (2017 (Phase 2)]  complaints concerning any suspected g but not limited to resident abuse, neglect, non-compliance with the advance direct the community.  Indicate the community based service services where the community based service program that the community based service	et, tives  and here as, ected f, he ts its, and			

CENTERS FO	OR MEDICARE & MEDICAID SERVICES			"A" FORM
STATEMENT O	F ISOLATED DEFICIENCIES WHICH CAUSE	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY
	TH ONLY A POTENTIAL FOR MINIMAL HARM		A. BUILDING:	COMPLETE:
FOR SNFs AND	NFs	245438	B. WING	12/8/2016
NAME OF PRO	VIDER OR SUPPLIER	STREET ADDRESS, C	TITY, STATE, ZIP CODE	I
TALAHI NU	URSING AND REHAB CENTER	1717 UNIVERSIT SAINT CLOUD,	Y DRIVE SOUTHEAST MN	
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE	S		
F 156	Continued From Page 2			
	(iii) Receipt of such information, and any a	mendments to it, mu	st be acknowledged in writing;	
	(g)(17) The facility must			
	(i) Inform each Medicaid-eligible resident, when the resident becomes eligible for Med	•	e of admission to the nursing facility and	
	(A) The items and services that are include resident may not be charged;	d in nursing facility s	ervices under the State plan and for which the	e
	(B) Those other items and services that the amount of charges for those services; and	facility offers and fo	r which the resident may be charged, and the	
	(ii) Inform each Medicaid-eligible resident paragraphs (g)(17)(i)(A) and (B) of this sec	-	ade to the items and services specified in	
	· · · · · · · · · · · · · · · · · · ·	facility and of charge	ime of admission, and periodically during the s for those services, including any charges for y's per diem rate.	
	(i) Where changes in coverage are made to State plan, the facility must provide notice		overed by Medicare and/or by the Medicaid ange as soon as is reasonably possible.	
	(ii) Where changes are made to charges for inform the resident in writing at least 60 da		ices that the facility offers, the facility must tation of the change.	
	(iii) If a resident dies or is hospitalized or is refund to the resident, resident representati- less the facility's per diem rate, for the days facility, regardless of any minimum stay or	ve, or estate, as applies the resident actually	cable, any deposit or charges already paid, resided or reserved or retained a bed in the	
	(iv) The facility must refund to the resident within 30 days from the resident's date of c		-	
	not conflict with the requirements of these This REQUIREMENT is not met as eviden	regulations. nced by:	vidual seeking admission to the facility must	
	6 residents (R64 and R91) reviewed who w			

			<del> </del>					
STATEMENT OI	F ISOLATED DEFICIENCIES WHICH CAUSE	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY				
	H ONLY A POTENTIAL FOR MINIMAL HARM		A. BUILDING:	COMPLETE:				
FOR SNFs AND	NFS	245438	B. WING	12/8/2016				
NAME OF PRO	VIDER OR SUPPLIER	STREET ADDRESS, C	STREET ADDRESS, CITY, STATE, ZIP CODE					
TALAHI NII	RSING AND REHAB CENTER	<b>I</b>	TY DRIVE SOUTHEAST					
	NOTICE REPORTED CENTER	SAINT CLOUD,	MIN					
D PREFIX CAG	SUMMARY STATEMENT OF DEFICIENCE	CIES						
F 156	Continued From Page 3							
	Findings include:							
	R64's admission Minimum Data Set (MD therapy while admitted in the facility.	S), dated 10/28/16, inc	licated R64 received physical and occupation					
	right to an immediate appeal through the R64's Medicare services were ending on	QIO or Quality Improv 11/7/16. R64 was disc identified Straits Healt	rage CMS 10095 (which explains a resident's vement Organization) on 11/4/16, identifying harged from the facility on 11/8/16. R64's h as the QIO. R64 should have received the rect form.					
	R91's admission MDS, dated 11/18/16, indicated R91 received physical and occupation therapy while a resident in the facility. R91 was a current resident at the facility.							
	on 11/24/16. Since R91 remained in the	facility, he also receive gations when Medicare	/22/16, regarding Medicare services ending ed the a SNF determination on continued stay e services end). R91 should have received the rect form.					
	During interview on 12/7/16, at 1:08 p.m. business office staff (BOS) stated the form CMS 10095 was form she had been instructed to issue. BOS stated she was unaware of any difference between forms CMS 10095 and CMS 10123, and did not know who the facility's QIO was. BOS stated she "never really looked at them" when delivering the liability notices to residents.							
	During interview on 12/8/16, at 2:56 p.m. director of nursing (DON) stated she was unaware of the difference in forms CMS 10095 and CMS 10123, nor who the facility used for their QIO.							
	Review of the CMS website identified the had been replaced with the CMS 10123.	e CMS 10095 form, ex	pired 10/31/2013, over three years ago, and					
	A copy of the facility's policy was reques	ted, but not provided.						

F5438027

Printed: 12/15/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION
A. BUILDING 01 - MAIN BUILDING 01

(X3) DATE SURVEY COMPLETED

245438

B. WING \_\_\_\_\_

12/07/2016

NAME OF PROVIDER OR SUPPLIER

#### TALAHI NURSING AND REHAB CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

#### 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304

.,,	SAINT	CLOUD, MI	N 56304	.,
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS	K 000		
	21			
	FIRE SAFETY			
	A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on December 07, 2016. At the time of this survey, Talahi Care Center was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.			
	Talahi Center is a 2-story building with a partial basement. The building was constructed at 4 different times. The original building was constructed in 1964 and was determined to be of Type II(000) construction. In 1984, an addition was added to the north which was determined to be of Type II(000)construction. Both of these buildings are 1 story building with partial basements. In 1998 and addition was added to the northwest that was determined to be Type II(000) construction and is 2 stories with no basement. In 2004 two additions were added to to the north that were determined to be Type II(000) construction and are both 2 stories with no basements. The plans for these 2 additions were reviewed on 02-03-03 to the 1985 Life Safety Code. Because the original building and the additions meet the construction type allowed for existing buildings, the facility was surveyed as one building.	*		
	The building is protected by a complete fire sprinkler system. The facility has a complete fire alarm system with smoke detection in the			
LABORATO	DRY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIG	GNATURE	TITLE	(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

J6VE21

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.

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

Printed: 12/15/2016 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE	& MEDICAID SEKA	ICES		OND NO. 0330-00
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED
	245438		B. WING	12/07/2016
NAME OF PROVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STATE, ZIP CODE	

TALAHI NURSING AND REHAB CENTER

1717 UNIVERSITY DRIVE SOUTHEAST

	SAINT	CLOUD, N	IN 56304	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	OR LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIATE	DATE

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a licensed capacity of 77 beds and had a census of 71 at the time of the survey.  The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		
			,	
~	19	-	4	
	2	v.	9	*
	e e			
	× 4	0		
	w (8)			
9.	d e		×	
-	.**			
	9			



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted December 23, 2016

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5438028, H5438046 & H5438047

Dear Ms. Smith:

The above facility was surveyed on December 5, 2016 through December 8, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaints numbered H5438046 & H5438047. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

Talahi Nursing & Rehabilitation Center December 23, 2016 Page 2

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure(s)

cc: Licensing and Certification File

PRINTED: 12/22/2016 FORM APPROVED

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND FLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COMPLETED
		00614	B. WING		C <b>12/08/2016</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
TALAHI N	URSING AND REHAB CE	NTER	ERSITY DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
2 000	Initial Comments		2 000		
	****ATTEN	TION*****			
	NH LICENSING CO	ORRECTION ORDER			
	144A.10, this correcting pursuant to a survey. found that the deficient herein are not correct not corrected shall be with a schedule of finithe Minnesota Depart.  Determination of whe corrected requires correquirements of the runumber and MN Rule. When a rule contains comply with any of the lack of compliance. Live-inspection with any result in the assessments.	ther a violation has been			
	that may result from rorders provided that at the Department within notice of assessment  INITIAL COMMENTS You have agreed to preceipt of State licens the Minnesota Depart Informational Bulletin	articipate in the electronic sure orders consistent with the electronic state of Health 14-01, available at the electronic state. The electronic state is a second or the electronic state of the elec			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

PRINTED: 12/22/2016 FORM APPROVED

Minnesota Department of Health

STATEMENT	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00614	B. WING		C <b>12/08/2016</b>	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
TALAHI N	URSING AND REHAB CE	NTER	ERSITY DRIVE	SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
2 000	Department of Health you electronically. Al is necessary for State enter the word "correctext. You must then in State licensure proce completion date, the corrected prior to elect Minnesota Department On 12/05/16 through Department's staff vist the following correction Please indicate in you correction that you have and identify the date of the In addition, an investight H5438047 was compared deficiency cited at Finvestigation of comp	orders being submitted to though no plan of correction e Statutes/Rules, please cted" in the box available for adicate in the electronic ss, under the heading date your orders will be ctronically submitting to the nt of Health.  12/08/16, surveyors of this sited the above provider and on orders are issued. Our electronic plan of ave reviewed these orders, when they will be completed.  gation of complaint leted and substantiated with F353 during the survey. An	2 000			

Minnesota Department of Health

STATE FORM 6899 J6VE11 If continuation sheet 2 of 2

PRINTED: 01/26/2017 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_ C B. WING 00614 12/08/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST **TALAHI NURSING AND REHAB CENTER** SAINT CLOUD, MN 56304 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 000 Initial Comments 2 000 \*\*\*\*\*ATTENTION\*\*\*\*\* NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/inf obul.htm The State licensing orders are delineated on the attached Minnesota

notice of assessment for non-compliance.

**INITIAL COMMENTS:** 

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

**Electronically Signed** 

01/04/17

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE	SURVEY LETED
7 (VD T E7 (IV	OF COTTLECTION	IDENTIFICATION NOISIBER.	A. BUILDING:			
		00614	B. WING		12/0	) 8/ <b>2016</b>
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
TALAHI I	NURSING AND REHA	R CENTER	/ERSITY DR .OUD, MN 5	IVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	you electronically. is necessary for State enter the word "cortext. You must then State licensure procompletion date, the corrected prior to e Minnesota Department".  On 12/05/16 throug Department's staff the following correction that you and identify the dat.  In addition, an investigation of contents and investigation of contents.	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the	2 000			
2 565	Plan of Care; Use Subp. 3. Use. A co	5 Subp. 3 Comprehensive omprehensive plan of care I personnel involved in the t.	2 565			1/17/17
	by: Based on observative review, the facility for care was implement	ent is not met as evidenced ion, interview, and document ailed to ensure the plan of nted for 4 of 5 residents (R41, reviewed who were		Completed		

Minnesota Department of Health

STATE FORM 6899 J6VE11 If continuation sheet 2 of 74

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00614			12/0	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 12/0	8/2016
		1717 UNI\		IVE SOUTHEAST		
IALAHI	NURSING AND REHA	SAINT CL	OUD, MN 50	6304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 2	2 565			
	dependent on staff (ADLs).	for activities of daily living				
	Findings include:					
	11/21/16, identified cognitively impaired from facility staff fo (ADL)'s. In addition	imum Data Set (MDS) dated R41 was moderately d and required total assistance r activities of daily living , R41 had no rejection of DS assessment period.				
	had an identified pr related to her (R41' plan identified R41 of 1 with ADL's and once a week as rec the care plan noted	dated 10/06/16, noted R41 oblem for ADL self-care deficit (s) dementia. Further, the care required extensive assistance was to receive a tub bath quested by R41. In addition, I R41 was to be provided a a full bath could not be				
	12:41 p.m. R41 sta weekly scheduled b	with R41 on 12/05/16, at ted she had not received bath on a "regular basis" and cause she required assistance th her ADL's.				
	received a tub bath 10/13/16, and 10/5/ medical record, the	orm identified R41 had on 11/21/16, 11/10/16, /16. Upon review of R41' s re was no indication that R41 with bathing from 10/05/16				
	nursing assistant (N should be documen	12/07/16, at 6:07 a.m. NA)-J stated all of R41's baths nted on the body audit form in her. NA-J stated she was				

Minnesota Department of Health

STATE FORM 6899 J6VE11 If continuation sheet 3 of 74

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION		E SURVEY PLETED
		00614	B. WING			C <b>08/2016</b>
	PROVIDER OR SUPPLIER NURSING AND REHA	B CENTER 1717 UNIV		STATE, ZIP CODE IVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 565	unaware of R41 ref was a "tough one" to When interviewed or registered nurse (Roreceiving at least on her care plan. Furth baths, "were not has audit forms.  During interview on director of nursing or residents in the fact baths as directed by INCONTINENCE R94's Admission Rohad dementia and rocontinence Evaluation indicated she was in was unknown, unawas not motivated to R94's Individual Recare plan) dated 12 incontinent of bower rounds (every two hindicated R94 was to reposition hersel R94's nursing assist instructed staff to to hours.  During continuous of 6:00 a.m. to 8:34 a. R94 was lying in heher nightgown on.	using a bath in the past, but to bathe.  on 12/07/16, at 10:16 a.m.  on)-D stated R41 should be the bath a week according to the bath a week according to the body.  12/07/16, at 11:26 a.m. with (DON) stated she was aware dility were not receiving their by the care plan.  ecord undated indicated she the the body the care plan.  ecord undated indicated she the the body of the b	2 565			

Minnesota Department of Health

STATE FORM 6899 J6VE11 If continuation sheet 4 of 74

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00614	B. WING			C <b>08/2016</b>
	PROVIDER OR SUPPLIER NURSING AND REHA	R CENTER 1717 UNI	-	TATE, ZIP CODE  VE SOUTHEAST  6304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 565	assistant (NA)-E lock walked by. At 8:13 room stated he was provide R94 with an re-entered the room which was moderat a small bowel move was red and excoris of the surface of the bottom was very retthe area. NA-E stated and this was the first provided cares to Rknow when R94 was During interview 12 nurse (RN)-C stated and should be toiled to her care plan.  FALL INTERVENTI R87's admission M 10/4/16, identified Fimpaired, used a will was at risk for falls activities of daily living R87's care plan, daingh risk for falls and "Dycem non-slip mat all times while recare plan did not dicushion to the wheel During observation was seated in his wand no Dycem was During the evening again observed seated.	oked into R94's room and a.m. NA-E entered R94's checking on R94, but did not by cares. At 8:34 a.m. NA-E and removed R94's pad ely soaked with urine, and had ement. R94's entire peri- area ated (damage or remove part eskin). NA-E stated her d, and applied peri cream to ted he started at 6:00 a.m. est time during his shift he had 194. NA-E said he did not as last changed.  707/16, at 1:10 p.m. registered d R94 was incontinent of urine ted every two hours according one one of the every two hours according the elchair for locomotion, and and dependent upon staff for ing.  108 ted 11/8/16 identified R87 at and included interventions for aterial to remain in wheelchair sident is up in chair." R87's rect staff to fasten the wedge				

Minnesota Department of Health

STATE FORM 6899 J6VE11 If continuation sheet 5 of 74

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					C	
		00614	B. WING		12/0	8/2016
NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
TALAHI I	NURSING AND REHA	R CENTER	OUD, MN 50	IVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 5	2 565			
	seated in his wheel	3/16, at 9:09 a.m. R87 was chair during breakfast, and no ed in R87's wheelchair.				
	assistant (NA)-F sta Dycem in his wheel	12/8/16, at 9:16 a.m. nursing ated R87 did not have any chair. NA-F stated she was being a fall intervention, or 's wheel chair.				
	director of nursing ( were communicate meetings. The DO	12/8/16 at 11:13 a.m., the (DON) stated fall interventions d to staff daily at morning N further stated staff were ber the interventions, and be				
		mplementation of resident uested, but not provided.				
	director of nursing (inservice staff about	THOD OF CORRECTION: The (DON) or designee could it implementing the care plan s to ensure compliance.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 570	MN Rule 4658.0409 Plan of Care; Revis	5 Subp. 4 Comprehensive ion	2 570			1/17/17
	care must be review interdisciplinary tea physician, a registe for the resident, and disciplines as deter	A comprehensive plan of wed and revised by an m that includes the attending red nurse with responsibility d other appropriate staff in mined by the resident's needs, practicable, with the				

Minnesota Department of Health

STATE FORM 6899 J6VE11 If continuation sheet 6 of 74

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00614			12/0	; 8/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	12/0	0/2010
TALAHI I	NURSING AND REHA	B CENTER	ERSITY DR	IVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE	(X5) COMPLETE DATE
2 570	Continued From participation of the guardian or chosen quarterly and within the comprehensive by part 4658.0400,  This MN Requirement by: Based on observation review, the facility for plan of care for falls reassessment was (R92) reviewed for Findings include:  R92's diagnoses, and dated 12/8/16, included in the care area assess and the care area assess and the care area assess and balance. The cworking with the pendurance, was made to assist with mobil During observation was seated in her working with the representation of the complete	ge 6 resident, the resident's legal representative at least seven days of the revision of resident assessment required subpart 3, item B.  ent is not met as evidenced on, interview and document ailed to update the resident with new interventions after a completed for 1 of 2 residents falls.  s identified on the face sheet added chronic respiratory reder and weakness. R92's in Data Set (MDS) dated moderately impaired cognition. The sament (CAA) for falls dated R92 was at risk for falls due to a with activity, unsteady gait CAA also indicated R92 was by for strengthening and aking progress, and staff were ity and transfers.  on 12/06/16 at 2:22 p.m., R92 wheel chair just outside her one shoes and socks, had	2 570			
	a nasal cannula in a cord, which lead	e right of the wheel chair, with place. Clipped to her shirt was directly to a TABS (a personal, g safety) alarm, fastened to eel chair.				
	Review of an Inves	tigation Report dated 11/22/16				

Minnesota Department of Health

STATE FORM 6899 J6VE11 If continuation sheet 7 of 74

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION		E SURVEY PLETED
		00614	B. WING			C <b>08/2016</b>
	PROVIDER OR SUPPLIER NURSING AND REHA	B CENTER 1717 UN		TATE, ZIP CODE  VE SOUTHEAST  3304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 570	room on 11/20/16. added an interventipersonal, movemer R92 when in wheel  The care plan, reviswas at high risk for anticipate and meecall light is within reencourage resident promote exercise for resident is wearing fall protocol; and Pand treat. R92's callarm intervention.  Review of the nursified R92 requimoderate fall risk, vand had a regular of R92's fall intervention.  During an interview nursing assistant (Nand used her nursing sheet, NA-I said the alarm, "but I know [alarm on." NA-I staresidents care planmeetings, but it work care plan, especiall.  During interview on director of nursing (care plan in the resupdated, as well as	an unwitnessed fall in her The interdisciplinary team on to place a TABS (a nt-detecting safety) alarm for chair or in bed.  Sed 11/21/16, identified R92 falls, and directed staff to: tresident's needs; be sure the ach and encourage to use; to participate in activities that or strengthening; ensure appropriate footwear; follow (physical therapy) evaluate re plan lacked the TABS  Ing aide care sheets, undated, red stand by assist, was a vas to bet toiled every 2 hours liet. The sheet did not include on to use the TABS alarm.  In 12/8/16 at 10:02 a.m., IA)-I stated she always carried by sheet. After reviewing the ere was nothing about R92's R92] is supposed to have the lated she learns of changes to sat the change of shift ald be important to know the lated she learns of changes to sat the change of shift ald be important to know the lated she learns of changes to sat the change of shift ald be important to know the lated she learns of changes to sat the change of shift ald be important to know the lated she learns of changes to sat the change of shift ald be important to know the lated she learns of changes to sat the change of shift ald be important to know the lated she learns of changes to sat the change of shift ald be important to know the lated she learns of changes to sat the change of shift ald be important to know the lated she learns of changes to sat the change of shift ald be important to know the lated she learns of changes to sat the change of shift ald be important to know the lated she learns of changes to sat the change of shift ald be important to know the lated she learns of changes to sat the change of shift ald be important to know the lated she learns of changes to sat the change of shift ald be important to know the lated she learns of changes to sat the change of shift ald the lated she learns of changes to show the lated she learns of changes to show the lated she learns of changes to she lated she learns of changes to she she lated she lated she lated she lated she lated she lated she l				

Minnesota Department of Health

STATE FORM 6899 J6VE11 If continuation sheet 8 of 74

AND DUAN OF CODDECTION IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY PLETED	
		00614	B. WING		12/0	)8/ <b>2016</b>
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	STATE, ZIP CODE		
TALAHI I	NURSING AND REHA	R CENTER		IVE SOUTHEAST		
(V4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	LOUD, MN 5	PROVIDER'S PLAN OF CORRECT	ION.	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETE DATE
2 570	Continued From pa	ge 8	2 570			
	indicated it is the po- all residents have a reflects their needs staff in providing re- indicated an interdis- for the developmen is responsible for sa	•	′			
	The director of nursing develop and implementated to care plandesignee, could prostaff related to the trevisions. The quality	THOD OF CORRECTION: sing (DON) or designee, could ment policies and procedures a revisions. The DON or ovide training for all nursing timeliness of care planity assessment and assurance erform random audits to				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 800	MN Rule 4658.0510 Staffing requiremen	0 Subp. 1 Nursing Personnel; nts	2 800			1/17/17
	home must have or number of qualified registered nurses, I nursing assistants t residents at all nurs in all buildings if mo	requirements. A nursing n duty at all times a sufficient nursing personnel, including icensed practical nurses, and to meet the needs of the ses' stations, on all floors, and one than one building is udes relief duty, weekends, cements.				
	This MN Requirement by:	ent is not met as evidenced				

Minnesota Department of Health

STATE FORM 6899 J6VE11 If continuation sheet 9 of 74

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	
	00614				12/0	; 8/2016
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	12/0	0/2010
TALAHI	NURSING AND REHA	B CENTER		IVE SOUTHEAST		
(X4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	OUD, MN 5	PROVIDER'S PLAN OF CORRECTION	)N	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	COMPLETE DATE
2 800	Continued From pa	ge 9	2 800			
	review, the facility f nursing staff to med 4 of 5 residents (R4 reviewed for activiti residents (R94) rev for 4 of 4 residents of 10 staff member NA-D, LPN-C, SM-	ion, interview and document ailed to provide sufficient et assessed resident needs for 11, R49, R94 and R87) es of daily living, 1 of 3 iewed for pressure ulcers, and (R3, R50, R80, R20) and 10 s (NA-A, NA-C, NA-B, TMA-A, A, SM-B, SM-B, RN-A) who th the lack of sufficient nursing		Completed		
	Findings include:					
	ASSESSED RESID MET:	ENT NEEDS NOT BEING				
	care was implement R49, R94 and R87)	ility failed to ensure the plan of nted for 4 of 5 residents (R41, n reviewed who were for activities of daily living				
	timely toileting assis (R41, R94) reviewe	ility failed to provide baths and stance for 2 of 3 residents of that were dependent upon f daily living (ADLs).				
	assistance for toilet reduce the risk of p	lity failed to provide timely ting and repositioning to ressure ulcer development for 94) identified at risk of				
	RESIDENT CONCI STAFFING:	ERNS WITH LACK OF				
		mum Data Set (MDS) dated				

Minnesota Department of Health

STATE FORM 6899 J6VE11 If continuation sheet 10 of 74

AND BLAN OF CORRECTION . IDENTIFICATION NUMBER:					DATE SURVEY COMPLETED		
00614		B. WING			C <b>08/2016</b>		
TALAHI NURSING AND REHAR CENTER 1717 UNIV				STATE, ZIP CODE  IVE SOUTHEAST  6304	·		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 800	required extensive on stated the facility la meet her needs tim staff were getting, "they had to rush thre enough staff. R3 si urine that same day with toileting quickly feel, "Upset and fur R3's Device Activity 12/8/16, identified to times:  On 11/25/16, at 11 for 22 minutes and On 11/25/16, at 11 for 43 minutes and On 11/27/16, at 11 for 18 minutes and On 11/30/16, at 11 for 15 minutes and On 11/30/16, at 6: for 21 minutes and On 12/2/16, at 8:3 59 minutes and 20 On 12/2/16, at 12: was on for 47 minutes and 20 The state of the facility needs and a state of the facility needs and a state of the facility needs and the facility needs an	assistance with ADLs  12/5/16, at 3:12 p.m cked sufficient nursin ely. R3 stated the nu Sloppy on cares," be ough them due to no tated she was inconti because she didn't renough adding it ma ious."  Report dated 11/24/ he following call light 17 seconds; 46 a.m. the call light 15 seconds; 00 p.m. the call light 15 seconds; 58 a.m. the call light 25 seconds; 59 a.m. the call light 4 seconds; 52 p.m. the call light 8 seconds; 7 a.m. the call light 8 seconds;	R3 Ig staff to ursing cause thaving nent of get help ade her  16 to response twas on was on was on was on twas on for a call light of tensive ig (ADLs).  R50 ompleted	2 800			

Minnesota Department of Health

STATE FORM 6899 J6VE11 If continuation sheet 11 of 74

AND DIAN OF CORRECTION IN INDENTIFICATION NUMBER:					TE SURVEY MPLETED	
00614			B. WING			C <b>08/2016</b>
	PROVIDER OR SUPPLIER	B CENTER 1717 UNI		STATE, ZIP CODE  IVE SOUTHEAST  6304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 800	the bathroom and, close" to having incomot enough staff to R50's Device Activities: On 11/30/16, at 2: for 23 minutes and On 11/30/16, at 11 for 19 minutes and On 12/7/16, at 7:1 20 minutes and 41  R80's annual MDS had intact cognition assistance with ADI During interview on stated the facility with R80 stated she had assistance before a on," to her bladder incontinence.  R80's Device Activities and On 12/7/16, at 7:1 28/16, identified the times: On 11/30/16, at 6: for 22 minutes and On 12/7/16, at 7:1 8 minutes and 41 On 12/7/16, at 7:1 8 minutes and 41 On 12/7/16, at 11: for 16 minutes and	at times, has come, "Pretty ontinence because there is assist him promptly."  ty Report dated 11/24/16 to he following call light response 01 a.m. the call light was on 32 seconds; 1:42 a.m. the call light was on 28 seconds; 3 a.m. the call light was on for seconds and; 3 a.m. the call light was on for seconds.  dated 11/15/16, identified R80 and required extensive Ls.  12/5/16, at 2:30 p.m. R80 as not adequately staffed. I waited up to 30 minutes for and at times just has to, "Hang so she doesn't have  ty Report dated 11/24/16 to he following call light was on 7 seconds; 0 a.m. the call light was on for seconds and; 36 a.m. the call light was on for seconds and; 36 a.m. the call light was on				

Minnesota Department of Health

STATE FORM 6899 J6VE11 If continuation sheet 12 of 74

AND DUAN OF CODDECTION IDENTIFICATION NUMBER.		(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	(X3) DATE	
			71. BOILDING.	<del></del>		;
		00614	B. WING			8/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TALAHI	NURSING AND REHA	B CENTER	/ERSITY DR OUD, MN 56	IVE SOUTHEAST		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)		COMPLETE DATE
2 800	Continued From pa	ge 12	2 800			
	10/6/16, identified Fimpairment.	R20 had moderate cognitive				
	stated the facility di provide timely assis stated he often has help, even after alre Further, R20 stated	12/5/16, at 6:11 p.m. R20 d not have enough staff to stance with his needs. R20 to wait up to 15 minutes for eady asking for assistance. I he had fallen in the hallway everal minutes before staff nim.				
	STAFF CONCERN	S WITH LACK OF STAFFING:				
	assistant (NA)-A sta short staffed, "A corresidents become us completed in a time [residents] can sen resident baths are user short staffed ar	12/6/16, at 2:06 p.m. nursing ated the facility is typically uple times a week," and upset their cares are not ely manner adding, "They se it." NA-A stated the not always completed if they ad staff run around the facility, their heads cut off," trying to d.				
	stated the nursing s days and being full main unit of the fac happening anymore get four aides." NA complete all of the like bathing, becaus NA-C stated the res when their baths ar Further, NA-C state the concerns with lanurse managers ar	on 12/6/16, at 2:28 p.m. NA-C staff was, "Really short," some staffed with four aides on the ility was not consistently adding, "We're lucky if we adding, "We're lucky if we assigned cares for residents, see of the lack of staffing. Sidents, "Get really upset," and cares aren't completed. And several staff had reported ack of sufficient staff to the addinistration of the facility, ust told, "We're working on it."				

Minnesota Department of Health

STATE FORM 6899 J6VE11 If continuation sheet 13 of 74

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION (A. BUILDING:		(X3) DATE SURVEY COMPLETED	
00614		B. WING			C <b>08/2016</b>	
	PROVIDER OR SUPPLIER	R CENTER 1717 UN	ADDRESS, CITY, S NIVERSITY DRI CLOUD, MN 56	VE SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 800	During interview on stated the memory just two NA staff and the memory care used three NA staff though because administration. "Standing around of NA staff was not enadequately or safel aides because of the stated resident care the lack of sufficient [resident] not getting Further, NA-B states the lack of staff had managers and administration. When interviewed the trained medication typically would only what we need," and result. TMA-A states staffed, "At least two had been complain cares not being continuous differences and the memory staffed with three NA-D stated if they the day, then cares good." Further, NA motion and bathing they were short state can get it, sometime.	12/6/16, at 2:45 p.m. NA-B care unit is typically staff with da cart nurse. NA-B stated nit used to be staffed with gh, however, it was changed ation felt people were just, own here." NA-B stated two lough to care for the residents y, "You need to have three ne behaviors we have." NA-B as was suffering as a result of at staffing adding, "They're g bathed," consistently. It is the determined the staffing adding, "They're g bathed," consistently. It is the seconcerns regarding a been, "Voiced strongly," to sinistration.  In 12/6/16, at 3:22 p.m. aide (TMA)-A stated the facility staff, "The bare minimum of discares were suffering as a led the facility was short sing about their baths and other pleted.  In 12/7/16, at 4:03 p.m. NA-D care unit was supposed to be last aff and a cart nurse. It did not have full staffing for suffer and were, "Not that also be last aff and a cart nurse. It did not have full staffing for suffer and were, "Not that also be last aff and a cart nurse of was not always completed if a ffed adding, "Sometimes you es you can't."	ty er			
		urse (LPN)-C stated several ed concerns about a lack of				

Minnesota Department of Health

STATE FORM 6899 J6VE11 If continuation sheet 14 of 74

AND BLAN OF CORRECTION TO TRANSPORT TO A MILITARE DE LA MILITARE D		` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED		
00614			B. WING		12/0	8/2016	
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
TALAHI	NURSING AND REHA	B CENTER		OUD, MN 50	IVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		CEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 800	Continued From pa	ge 14		2 800			
	sufficient staffing in residents had partic baths not being cor stated she had repo staff to the adminis	cularly compl npleted. Fur orted conceri	ained about their ther, LPN-C				
	During interview on human resources of in charge of making the facility. The factor communicate with selevels for each day staffing for the facil nurses or TMA staff there was less NAs weren't scheduled to	lirector (HRD of the staffing sility used a c staff" to deter HRD stated ity was nine l f; however or staff schedule	assignments for shart and, "Just rmine the staffing d the typical NA staff with three in the weekends ed because baths				
	An undated Staff to was provided by HF determining staff le identified different oppulation numbers number of NA staff have provide care fidentified the follow facility census of 70	RD as the me vels in the fa groupings of s along with a and, "RN/LP or each shift ing desired s	ethod for cility. The chart resident a pre-determined N/TMA" staff to . The chart staffing levels for a				
	- NA for AM shift: 8 - NA for PM shift: 6 - NA for night shift: - Nurse/TMA for AN	3.9 - 7.1 2.8 - 2.9					
	- Nurse/TMA for PN - Nurse/TMA for nig	/I shift: 3.5 -					
	During an anonymostaff member (SM)-staffed and baths, result. Further, SM concerns to them a	-A stated the 'Usually don' -A stated res	facility was short t get done," as a sidents had voiced				

Minnesota Department of Health

STATE FORM 6899 J6VE11 If continuation sheet 15 of 74

AND DUAN OF CODDECTION IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY PLETED	
		00614	B. WING		12/0	)8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE	•	
TALAHI	NURSING AND REHA	R CENTER	/ERSITY DRI OUD, MN 56	VE SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 800	facility adding these few times a week."  During an anonymostated the staff end "Couple times a we being answered slo provided consistent used to have pool shelpful because, "A there," to help with report these concertold, "Try to do your they were unaware administration to has staffing in the facility or and each unit working. In addition used between the runit to complete bas SM-C stated complicares was "More diand cares were suffiand cares were suffiand cares were suffiand several resident constaffing, including a evening prior where minutes for assistation was, "An extended"	e complaints were heard, "A bus interview on 12/7/16, SM-B up working short staffed a, ek," which results in call lights wer and cares not being ly. SM-B stated the facility staff available which was t least [you] had that person cares. SM-B stated the staffers to the nurses, but are just best." Further, SM-B stated of anything being done by undle or address the lack of y.  In the staffing a couple months should have at least two aides in, two bath aides were being main unit and memory care the and help on the floor. The staffing as a result. SM-C lent and family concerns had ares not being completed in which was upsetting adding,	2 800			

Minnesota Department of Health

STATE FORM 6899 J6VE11 If continuation sheet 16 of 74

AND DIAN OF CODDECTION IDENTIFICATION NUMBER			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
			A. BUILDING:			`
		00614	B. WING		12/0	8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TALAHI	NURSING AND REHA	R CENTER	VERSITY DR .OUD, MN 50	IVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 800	Continued From pa	ge 16	2 800			
		k of staffing to her which were aff coordinator and the director				
	the facility. The fact to determine staffin and acuity was also the staffing in the fact because the care where the care where observed to where the care where observed to where the care where observed to where the care where the c	interviewed about staffing in cility typically used a guideline g levels, however case load of considered. The DON stated acility, "Was excellent," was good adding no issues had warrant an increase in staffing ood." The DON stated she h staff during the morning ware a, "Couple of concerns," orward about the lack of added she didn't feel there was in to justify changing the effacility. Further, the did the facility was looking at we care nursing model and dijusted to reflect this.  The partment Staffing policy of the nursing floor," and the daily check in sheets to hursing staff to work groups, ace a call in if one occurs.  THOD OF CORRECTION: The and/or designee could review g staffing patterns to evaluate tion of staff is needed to cares needs are met.  R CORRECTION: Twenty-one				

Minnesota Department of Health STATE FORM

AND BLAN OF CORRECTION . IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
00614					12/0	) 8/2016
	PROVIDER OR SUPPLIER	B CENTER 1717 UNI		STATE, ZIP CODE RIVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 17	2 830			
2 830	Proper Nursing Car Subpart 1. Care in receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the iin in bed or the resident	2 830			1/17/17
	by: Based on observati review, the facility f supervision, and int to prevent accident (R87, R49, R75, R3 addition, the facility properly fastened a to promote safety f had loose bed rails  Findings include:  FALLS	ent is not met as evidenced ion, interview, and document ailed to ensure appropriate terventions were implemented hazards for 4 of 5 residents 37) reviewed for accidents. In failed to ensure bed rails were and secured to the bed frame or 1 of 20 residents (R3) who		Completed		
	10/4/16, identified Fused a wheelchair for falls.  R87's admission Ca	R87 was cognitively impaired, for locomotion, and was at risk are Area Assessment (CAA), entified R87 was at risk for falls				

Minnesota Department of Health

STATE FORM 6899 J6VE11 If continuation sheet 18 of 74

i l	(X3) DATE SURVEY COMPLETED	
00614 B. WING 12/08	3/2016	
NAME OF PROVIDER OR SUPPLIER  TALAHI NURSING AND REHAB CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE  1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
related to unsteady gait and impaired balance. The CAA also indicated R87 had difficulty maintaining balance while sitting, indicating R87 would "Lean back at times he will straighten his legs."  Facility Incident Reports, reviewed from 10/9/16 to 11/26/16, identified R87 had seven falls in the facility since admission. An incident report, dated 10/22/16, indicated R87's wheelchair cushion had slid out of R87's wheelchair causing him to fall to the floor. The report indicated Dycem (non skid sheet) was placed in R87's wheelchair and added to the care plan.  R87's care plan, dated 11/8/16, identified R87 was a high risk for falls. R87's care plan included the intervention "Dycem non-slip material is to remain in wheelchair at all time while resident is up in chair." R87's care plan also indicated he received a new wheelchair cushion to assist with fall prevention.  During observation on 12/7/16, at 1:36 p.m., R87 was seated in his wheelchair while eating lunch. and no dycem was observed in the wheelchair. During observation on 12/8/16, at 9:09 a.m. R87 was seated in his wheelchair floring observation on 12/8/16, at 9:09 a.m. R87 was seated in his wheelchair floring observation on 12/8/16, at 9:09 a.m. R87 was seated in his wheelchair floring observation on 12/8/16, at 9:09 a.m. R87 was seated in his wheelchair floring observation on 12/8/16, at 9:09 a.m. R87 was seated in his wheelchair floring observation on 12/8/16, at 9:09 a.m. R87 was seated in his wheelchair floring observation on 12/8/16, at 9:16 a.m. nursing assistant (NA)-F stated R87 did not have dycem in his wheelchair. NA-F stated she was unaware of dycem being a fall intervention, or was needed for R87's wheel chair.  During interview on 12/8/16, at 9:38 a.m.		

Minnesota Department of Health

STATE FORM 6899 J6VE11 If continuation sheet 19 of 74

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00614	B. WING			)8/ <b>2016</b>
	ROVIDER OR SUPPLIER	R CENTER 1717 UNI		STATE, ZIP CODE RIVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
	needed the dycem is received the new will provided a non slip plan had not been redycem.  During interview on occupational therapethe dycem in his who cushion did not provisurface.  During interview on director of nursing (were communicated meetings. The DOI expected to remem implementing them.)  A facility policy titled 9/1/16, directed all rewould be assessed interventions on the were to be implemented by a quarterly MDS R49 was severely coneeded supervision.  A Progress Note daindicated R49 had proving cup to her releft arm and lap. Releft arm approximated reddened area on left.	N)-C stated R87 no longer in his wheelchair once R87 heelchair cushion, which surface. RN-C stated the care evised to discontinue the  12/8/16, at 10:02 a.m. bist (OT)-A stated R87 needed neelchair, and his wheelchair vide an appropriate non slip  12/8/16 at 11:13 a.m., the DON) stated fall interventions d to staff daily at morning N further stated staff were ber the interventions, and be developed.  I "Fall Prevention," dated new admissions to the facility for fall risk. The fall care plan and assessment				

Minnesota Department of Health

STATE FORM 6899 J6VE11 If continuation sheet 20 of 74

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)	) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
	00614	B. WING			C 08/2016
NAME OF PROVIDER OR SUPPLIER			STATE, ZIP CODE	•	
TALAHI NURSING AND REHAB C	FNIFR	OUD, MN 56	IVE SOUTHEAST 6304		
PREFIX (EACH DEFICIENCY MUS	IENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
prior to getting meal. V breakfast client grabbe her mouth and accident her left arm and lap." Vin place for staff to fill chalf full and add ice cult prior to serving, signag coffee carafes in east k intervention.  R49's care plan dated (resident required a meacueing by staff to eat. coffee fill cup half-full a placing at the table, coffee fill cup half-full a placing assistant (NA)-lunch tray along with a There was no ice in the observed coming from During interview on 12/stated she was not away they provide to keep R4  During interview on 12/registered nurse (RN)-lishould be luke warm by then stated R49's care be placed in her cup to water. RN-B thought the had changed.  RESIDENT TO RESIDENTS quarterly Minimum	itting at table in dinning ient was given beverages While client was waiting for at the cup, moved it toward itally spilled her coffee on Writer placed intervention coffee/hot liquid containers bes to cool to room temp per placed in front of the kitchen to remind staff of 08/10/16, indicated "This chanical soft diet and Cut up food as needed, and cool with ice prior to ffee should be luke-warm."  107/2016, at 12:34 p.m., and coffee, and steam was the top of the coffee cup.  107/16, at 12:40 p.m. NA-G are of any interventions 49's coffee luke warm.  107/16, at 2:22 p.m., B stated R49's coffee y adding water. RN-B plan indicated ice should be keep it luke warm, not hat intervention for R49	2 830			

-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBI	ΞD.	2) MULTIPLE BUILDING: _	E CONSTRUCTION	(X3) DATE COMPI	
		00614	В. У	WING		12/0	; 8/2016
NAME OF	PROVIDER OR SUPPLIER	S	TREET ADDRES	SS, CITY, S	TATE, ZIP CODE		
TALAHI	NURSING AND REHA	RCENTER	717 UNIVER AINT CLOUI		VE SOUTHEAST 304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FUI SC IDENTIFYING INFORMATIO	LL F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	had a behavior of restaff, related to dem disturbance. The cassist R75 to develor of coping and interato express feelings  R37's quarterly MD was severely, cognidiagnoses which incomplete another resident (Rinstructed R75 was another resident (Rinstructed R75 walksided upper body hand hit R75 in the hinjuries. R75 was aif she couldn't keep room and no furthe  An Incident Report on 10/12/16, in the standing near R37, Staff offered R75 regive R37 some persome agitation towawas in Broda chair wheelchair) and R7 walker. She preced her a left sided hug make a fist with her	ed 09/29/16, indicated appeatedly asking for cenentia with behavior care plan directed staff op more appropriate moting, and to encourage appropriately.  S dated 11/1/16, indicated tively impaired and had cluded dementia.  The note indicated ay away from the other space, because R37 wed over and gave R37 aug. R37 swung their rigead. There were no appear advised to go to he to herself. R75 did gor behaviors were identificated afternoon staff had note showing concern for her assurance and asked I sonal space as R37 disards others at this time.	she rtain to ethods e R75 ted she I  n. d staff as a left pht fist oparent er room to her ied. ed that ed R75 er. ner to played R37 g her nd gave to R75.	830			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00614		B. WING			C <b>08/2016</b>
_	PROVIDER OR SUPPLIER	B CENTER	1717 UNI		STATE, ZIP CODE IVE SOUTHEAST 5304		
(X4) ID PREFIX TAG		TEMENT OF DEFICI / MUST BE PRECED SC IDENTIFYING INI	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 830	the altercation with with interventions in after R37 struck R7 resident to resident residents safe.  LOOSE SIDE RAIL R3's quarterly Minin 8/11/16 identified R required extensive daily living (ADL's). morbid obesity and weakness.  During observation bed was fitted with approximately 24" (height. The rails with a screw. Whe moved back and for bed frame.  During interview on registered nurse (Refelt "very loose" and Further, RN-E state rails to assist her in When interviewed of stated the side rails and were difficult to loose.  During interview on registered nurse (Registered nurse (Registered nurse) and were difficult to loose.	R37. There wan plemented for 75, to help reduce altercations an Smum Data Set (3 was cognitive assistance with R3 had a diagrageneralized muon 12/05/16, at 3 bilateral, quarterinches) in lenguere fastened to a grasped, each rth approximate 12/05/16, at 3: N)-E stated (R3 dwas a safety ried R3 frequently sitting up in bean 12/05/16, at 3: had always bean 12/05/16, at 6: had always	either resident, be the risk of d keep both  MDS) dated ly intact and activities of mosis of severe uscle  3:10 p.m. R3's in bed frame, in rail could be ely 2" from the  19 p.m. with B's) side rails isk for R3. In used the side d.  3:22 p.m. R3 en "very loose" were that  53 p.m. the side rails felt at risk for falls sk if the side				
	On 12/08/16, at 1:0		ed the usual				

Minnesota Department of Health

STATE FORM 6899 J6VE11 If continuation sheet 23 of 74

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE COMI			
		00614	B. WING			C <b>08/2016</b>
NAME OF I	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY,	STATE, ZIP CODE	·	
TALAHI I	NURSING AND REHA	R CENTER	NIVERSITY DF CLOUD, MN 5	RIVE SOUTHEAST 66304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 23	2 830			
	maintenance with c	for facility staff to notify concerns with paper slips. there was no system in place nance.				
	identified staff mem rail is safe, provide	ed, "Side Rails" dated 6/11/16 bers are to assess the side education to residents and a ufacture's instructions.				
	director of nursing of and reeducate all so procedures to ensu accidents were read implemented and p accident hazards. T	THOD OF CORRECTION: The price of the designee could review taff on the policies and are that all residents at risk for seessed, interventions properly supervisor to prevent the director of nursing or her relop monitoring systems to impliance.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one	e			
2 835	MN Rule 4658.0520 Proper Nursing Car	0 Subp. 2 A Adequate and re; Criteria	2 835			1/17/17
	proper care. The cadequate and proper Evidence of adequate	ate care and kind and lent at all times. Privacy mus	t			
	by: Based on observati	ent is not met as evidenced ion, interview, and document ailed to provide baths and		Completed		

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00614			12/0	; 8/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	12/0	0/2010
		1717 UNI\		IVE SOUTHEAST		
ІАСАПІ	NURSING AND REHA	SAINT CL	OUD, MN 50	6304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 835	Continued From pa	ge 24	2 835			
	(R41, R94) reviewe	stance for 2 of 3 residents ed that were dependent upon f daily living (ADLs).				
	Findings include:					
	11/21/16, identified cognitively impaired for ADL's. In addition	imum Data Set (MDS) dated R41 was moderately d and required total assistance on, R41 had no rejection of DS assessment period.				
	an identified proble related to her (R41) plan identified R41 assistance of one value tub bath once a vaddition, the care p	dated 10/06/16, noted R41 had m for ADL self-care deficit (s) dementia. Further, the care required an extensive with ADL's and was to receive week as requested by R41. In lan noted R41 was to be bath when a full bath could not				
	12:41 p.m. R41 sta weekly scheduled b	with R41 on 12/05/16, at ted she had not received paths on a "regular basis "and cause she required assistance r her ADL's.				
	received a tub bath 10/13/16, and 10/5/ medical record, the	orm identified R41 had on 11/21/16, 11/10/16, /16. Upon review of R41's re was no documentation of s from 10/05/16 through				
	nursing assistant (N should be documen the bath book. Furt	12/07/16, at 6:07 a.m. NA)-J, stated all of R41's baths atted on the body audit form in the NA-J stated she was fusing a bath in the past and				

Minnesota Department of Health

STATE FORM 6899 J6VE11 If continuation sheet 25 of 74

-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/ IDENTIFICA	SUPPLIER/CLIA FION NUMBER:	` '	E CONSTRUCTION		SURVEY PLETED
		00614		B. WING			C <b>08/2016</b>
	PROVIDER OR SUPPLIER	B CENTER	1717 UNI		STATE, ZIP CODE  IVE SOUTHEAST 6304	·	
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L		DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 835	was a "tuff one "to law as a "tuff one "tu	path.  on 12/07/16, at 1/2/07/16, at 1/2/07/07/16, at 1/2/07/16, at 1/2/07/16, at 1/2/07/16, at 1/2/07/16, at 1/2/07/16, at 1/2/	41 should be k. RN-D stated y "according to have been 1:26 a.m. with she was aware were not 1:26 a.m. with she was aware will receive a 1:26 a.m. with she will receive a 1:26 a	2 835			
	bladder and wore a further indicted it wurge to void and did During continuous 6:00 a.m. to 8:34 a. R94 was lying in he	as unknown if I not use the to observation or .m. (2 hours ar	R94 had an bilet.  12/07/16, from and 34 minutes)				

Minnesota Department of Health

STATE FORM 6899 J6VE11 If continuation sheet 26 of 74

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00614			12/0	; 8/2016
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 12/0	0,2010
TALAHI I	NURSING AND REHA	B CENTER	ERSITY DR	IVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 835	observed during thi assistant (NA)-E low walked by. At 8:13 room stated he was provide R94 any care-entered the room which was moderat a small bowel move was red and excoris of the surface of the bottom was very rethe area. NA-E stated this was the first provided cares to Fix know when R94 was risk for skin breakd and changed every SUGGESTED MET The director of nurs responsible for mean residents. The facil system to ensure of the findings to the Country of the provided that the first provided cares to Fix the system to ensure of the findings to the Country of the provided cares to Fix the provided cares to Fix the system of the findings to the Country of the findings to the findings of the findings to the findi	There was no staff for R94 s time. A 7:52 a.m. nursing oked into R94's room and a.m. NA-E entered R94's checking on R94, but did not tres. At 8:34 a.m. NA-E and removed R94's pad rely soaked with urine, and had rement. R94's entire peri- area rated (damage or remove part e skin). NA-E stated her d, and applied peri cream to ted he started at 6:00 a.m. st time during his shift he had resulted to the started at 6:00 a.m. st time during his shift he had resulted to the started at 6:00 a.m. st time during his shift he had resulted to the started at 6:00 a.m. st time during his shift he had resulted at 6:00 a.m. st time during his shift he	2 835			
2 900	(21) days.  MN Rule 4658.0529 Ulcers	5 Subp. 3 Rehab - Pressure	2 900			1/17/17

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00614	B. WING		12/0	) 8/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 12/0	0,2010
TALAHI	NURSING AND REHA	R CENTER	/ERSITY DR OUD, MN 50	IVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	Subp. 3. Pressure comprehensive res of nursing services development of a nursing services that:  A. a resident who without pressure sores unle condition demonstrate authenticates, that  B. a resident who receives necessary promote healing, prom	sores. Based on the ident assessment, the director must coordinate the ursing care plan which  o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and tho has pressure sores y treatment and services to revent infection, and prevent yeloping.  ent is not met as evidenced on, interview and document alled to provide timely ing and repositioning to ressure ulcer development for 04) identified at risk of  nission Record indicated R94 e/01/16, which included ntia and multiple sclerosis (A e immune system eats away vering of nerves). R94's	2 900	Completed		
	completed.  A Braden Skin assepressure ulcer risk)	essment (scale for predicting dated 12/01/16, indicated lly moist skin, was bed fast.				

Minnesota Department of Health

STATE FORM 6899 J6VE11 If continuation sheet 28 of 74

	NT OF DEFICIENCIES OF CORRECTION		R/SUPPLIER/CLIA ATION NUMBER:	` '	E CONSTRUCTION		SURVEY PLETED
				A. BUILDING.			C
		00614		B. WING			08/2016
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TALAHI	NURSING AND REHA	B CENTER		VERSITY DR OUD, MN 50	IVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC' REGULATORY OR L		EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 900	had very limited mo of friction and shear score of 14 which in risk for developing.  R94's Individual Recare plan) dated 12 incontinent of bower toileted on rounds. Indicate she was at the provided care she was at the provided during the assistant (NA)-E lowalked by. At 8:13 room and said he was red and excori of the surface of the bottom was very rethe area. NA-E state and this was the fir provided cares to Face know when R94 was the provided cares to Face when the provided care whe	obility, with a process of the control of the contr	sment had a was at moderate cer.  Plan (temporary ed R94 was and was to be lan did not sure ulcers.  In 12/07/16, from and 34 minutes) right side with staff for R94 52 a.m. nursing l's room and ntered R94's on R94, but did 34 a.m. NA-E and R94's pad ith urine, and had entire peri- area e or remove part stated her d peri cream to d at 6:00 a.m. his shift he had id he did not ed.  O p.m. registered continent of own. She should nours and				
	Breakdown." review "Properly identify a	ved 3/2016, di	irected staff to				

Minnesota Department of Health

STATE FORM 6899 J6VE11 If continuation sheet 29 of 74

STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00614			12/0	
NAME OF F		00614			12/0	8/2016
	PROVIDER OR SUPPLIER	1717 IINI\		STATE, ZIP CODE  IVE SOUTHEAST		
TALAHIN	NURSING AND REHA	RCENTER	OUD, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	Continued From page 29		2 900			
	skin integrity, and p preventative measu	ent modalities for wounds				
	director of nursing ( inservice staff rega plan to ensure appr	THOD OF CORRECTION: The (DON) or designee could rding implementation of a care opriate treatment of pressure dit to ensure compliance.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 910	MN Rule 4658.0529 Incontinence	5 Subp. 5 A.B Rehab -	2 910			1/17/17
	have a continuous management to recunnecessary use of comprehensive reshome must ensure  A. a resident without an indwellinunless the resident that catheterization  B. a resident with receives appropriate prevent urinary trace	nce. A nursing home must program of bowel and bladder duce incontinence and the fatheters. Based on the ident assessment, a nursing that: ho enters a nursing home greatheter is not catheterized solinical condition indicates was necessary; and no is incontinent of bladder treatment and services to infections and to restore as er function as possible.				
	This MN Requirements	ent is not met as evidenced				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00614	B. WING		12/0	) 8/2016
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	12/0	0/2010
TALAHI	NURSING AND REHA	R CENTER	/ERSITY DR OUD, MN 50	IVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE	(X5) COMPLETE DATE
2 910	Continued From page 30		2 910			
	Based on observation, interview, and document review, the facility failed to comprehensively reassess a change in continence status for 1 of 3 residents (R38) reviewed for urinary incontinence			Completed		
	Findings include:					
	08/04/16, indicated urine. The quarterly indicated R38 was (7 or more episode one episode of con assessment (CAA) was on a diuretic (rassistance with toile identified R38 did n	inimum Data Set (MDS) dated R38 was always continent of MDS dated 10/31/16, frequently incontinent of urine of incontinence but at least tinence). The care area dated 8/10/16, identified R38 educes fluid), and needed eting. Further, the CAA ot always ask for assistance pairment, and staff were to be hours.				
		ted 08/09/16, indicated he assistance of one for toileting.				
	thru 8/4/16, indicate of urine. A subseque 10/26/16 thru 11/1/incontinent of urine	ocumentation from 7/28/16 ed R38 was never incontinent uent bladder assessment from 16, indicated R38 was nine times, which was a om his previous assessment in				
	indicated R38 did n without incontinenc to toilet and was for assessment on 11/ continence was left from continent to fre there were no chan	ler assessment dated 11/1/16 ot always void appropriately e, was independent, but slow regetful. This portion of R38's 1/16 to indicate changes in blank. Although R38 went equently incontinent of urine, ges to R38's interventions to event the incontinence.				

Minnesota Department of Health

STATE FORM 6899 J6VE11 If continuation sheet 31 of 74

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION (X3) DATE S  COMPLE			
		00614	B. WING			C <b>08/2016</b>
NAME OF	PROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY,	STATE, ZIP CODE		
I TALAHINI RSING AND REHAR CENTER			UNIVERSITY DF T CLOUD, MN 5	RIVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 910	Continued From pa	ge 31	2 910			
		/06/16, at 3:40 p.m. R38's I)-C stated R38 wore a pad				
		12/08/16, at 1:45 p.m. nursesisted R38 to toilet and R3 ine.				
	nurse (RN)-D stated but now was freque RN-D stated she co to the Bladder 7-Da nurses on the floor completing the asso with changes. RN- changes made to F	d/07/16, at 1:19 p.m. registed R38 was continent of uring ently incontinent of urine. It is impleted the MDS according documentation, and the were responsible for essment and following thro D stated there were no R38's toileting program and f nursing (ADON) should have beded.	ugh the			
	Assessment policy 08/2016, indicated assessment will ensowel or bladder in appropriate treatment.	d, "Bowel and Bladder and procedure," effective the residents' comprehensi sure that each resident, wit continence, will receive ent and services to restore I or bladder functioning as	h			
	The director of nurs all residents who no to assure they are r treatment/services toileting. The direct could conduct rand	THOD OF CORRECTION: sing or designee, could revieeded assistnace with toiled receiving the necessary to prevent potential decline or of nursing or designee, om audits of the delivery operopriate care and services	ing, in f			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:  COMP				
						С	
		00614	B. WING		12/0	8/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY,	STATE, ZIP CODE			
TALAHI	NURSING AND REHA	R CENTER	NIVERSITY DE CLOUD, MN 5	RIVE SOUTHEAST			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	iON	(X5)	
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETE DATE	
2 910	Continued From pa	ge 32	2 910				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-on	е				
2 960	MN Rule 4658.0600 Food Quality	Subp. 1 Dietary Service -	2 960			1/17/17	
		uality. Food must have taste ance that encourages reside d.					
	by: Based on observati review, the facility faci	ent is not met as evidenced on, interview, and document ailed to ensure prepared food served for 1 of 1 residents ned about poor tasting food. o affect 10 of 10 residents illity as having received the	ds	Completed			
	Findings include:						
		imum Data Set (MDS) dated R69 had moderate cognitive					
	meal service on 12/(DA)-A wheeled a not begin serving the serving pan into the a loaf of sliced white exposed. DA-A begingle pieces of breathem on several different the pan with o	of the Rosewood Unit evening 1/5/16, at 6:18 p.m. dietary aid nobile cart into the kitchenette meal. DA-A placed a metal esteam table which contained be bread with only its top crusty gan to plate food by removing the top portion of crust or the food by removed only the top portion of crust or the food by	e e e lic d d ss				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	00614	B. WING			C <b>08/2016</b>	
NAME OF PROVIDER OR SUPPLIER  TALAHI NURSING AND REHAB CENT	1717 UNI\		STATE, ZIP CODE IVE SOUTHEAST 5304	·		
(X4) ID SUMMARY STATEMENT PREFIX (EACH DEFICIENCY MUST E REGULATORY OR LSC IDEN'	BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SECTION SECTION OF CROSS-REFERENCED TO THE APDEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
seasoning. DA-A served pit to several residents alone.  When DA-A finished servi sample tray was requested bread was not toasted, but with only visible yellow seasorust. The surveyor tasted lacked any garlic flavor.  When interviewed on 12/5 stated the white bread was toast, however, "Just the tappeared to have any seasoding, "I think it could use Further, DA-A stated she sapproximately ten resident service.  When interviewed on 12/5 stated the garlic bread sermeal lacked flavor and was tasted better."  During interview on 12/7/1 dietary director (DD) stated prepared the garlic toast in "Didn't like the way it looked DD stated the cook should out and buttered it separation the bread and more flated A facility supplied Garlic B Preparation dated 12/7/16 to, "Brush melted margarity bread," for serving.  An undated facility Resided Responsibilities Related to Operations policy, undated	ng resident trays, a d by the surveyor. The t rather soft and limp, asoning on the top d the bread and it  6/16, at 6:55 p.m. DA-A s supposed to be garlic op of the bread" soning or coloring e a little bit more garlic." served the bread to ts during the meal  6/16, at 6:56 p.m. R69 red for the evening as not very good, "I've  6, at 3:28 p.m. the d the cook had incorrectly adding she, ed" when it was served. d have laid each piece tely to, "Get more butter vor."  read Recipe f, directed cooking staff ine on each slice of  ents' Rights and o Food Service	2 960				

Minnesota Department of Health

STATE FORM 6899 J6VE11 If continuation sheet 34 of 74

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					(	
		00614	b. WING		12/0	8/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TALAHI I	NURSING AND REHA	B CENTER	OUD, MN 50	IVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 960	Continued From pa	ge 34	2 960			
		nourishing, palatable, and s that meet daily nutrition and				
	dietitian and food se policies and proced address food palata be trained. Audits of residents randomly	THOD OF CORRECTION: The ervice director could ensure lures are accurate and ability. Appropriate staff could ould be conducted and interviewed for satisfaction. udits could be brought to the or review.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21235	MN Rule 4658.0700 Director;Develop st		21235			1/17/17
	conjunction with the director of nursing s for:  C. the development of the conjunction of the conjunction with the director of nursing states.	he medical director, in e administrator and the services, must be responsible opment of standards of I care to provide guidance to s;				
	by: Based on interview facility failed to colla director to address continuity for 1 of 1	and document review, the aborate with the medical concerns of physician residents (R31) who did not be under a consistent		Completed		

6899

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00014	B. WING		10/0	
		00614	B. WING	· · · · · · · · · · · · · · · · · · ·	12/0	8/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TALAHI	NURSING AND REHA	RCENTER	IVERSITY DR LOUD, MN 56	IVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21235	Continued From pa	ge 35	21235			
	8/26/16, indicated n	inimum data set (MDS), dated to cognitive impairment.				
	indicated she had b following a hospita also indicated a foll primary physician a R31's diagnosis list identified an admiss infection) along with nephropathy (kidne	narge report, dated 8/19/16, been admitted to the facility I stay related to leg pain, which ow up appointment with her t the facility in one week.  I, dated 12/7/16, further sion diagnosis of cellulitis (sking a history of diabetes with y damage), heart failure, and pulmonary disease.				
	A review of physicia notes identified the	an and physician assistant (PA following:				
	assessed by her pri The note indicated visits due to her "Ac conditions with multi-	ceived a visit and was imary medical doctor (MD-B). that R31 needed monthly dvanced multiple comorbid tiple medications" and that acement in skilled nursing ransfer care."				
	R31 had an appoint different physician, assessed R31. The be contacting the faconcerning R31's n care." On 10/24/16, as a patient recomm	ys after her last physician visit tment to establish care with a MD-C outside the facility who note identified MD-C would acility to "Clarify the issue on-eligibility for in-facility MD-C declined to take R31 mending an Internal Medicine ed to place referral for the	,			
	an appointment with	s after her admission, R31 had h a PA-A. After assessing declined to take R31 as a	I			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	00614	B. WING		12/0	; 8/2016	
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE	•		
TALAHI NURSING AND REHAB C	PENTER	ERSITY DRI	VE SOUTHEAST 3304			
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES JST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
recommended an Inter On 11/18/16, 91 days a R31 had an appointme facility who completed became her primary ph  A facility Progress Note the facility had request Director (MD)-A to follo because they were una R31. A Progress Note the facility Medical Dire follow R31 as a patient  R31's medical record la Medical Director-A had of R31 in September, within 30 days of her la There was also no indi Director-A had been co establish care with a pi  During interview on 12 stated she felt "Abando experience and "Didn't down" referring to not la consistent physician. F seen by the Medical Di he couldn't follow her of R31 stated since the fa wouldn't see her, she " was "Just hoping and p  During interview on 12 stated he wasn't able to due to her younger age hadn't seen R31 in per	after she was admitted, ent with a MD-D outside the an assessment of R31 and hysician.  e, dated 9/26/16, indicated ted the facility's Medical ow R31 starting 9/27/16, able to find a physician for e, dated 10/26/16, indicated ector-A had declined to t.  lacked any indication the d completed an assessment when R31 was not seen ast physician assessment. ication the Medical ontacted to assist R31 to orimary physician.  2/7/16, at 3:50 p.m. R31 oned and frustrated" by the t like the way things went being followed by a R31 stated she hadn't been director, but had been told due to age and insurance. acility's Medical Director "was hanging again" and praying things got better."	21235	DETIONENCY)			

Minnesota Department of Health

STATE FORM 6899 J6VE11 If continuation sheet 37 of 74

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY PLETED	
		00614	B. WING		12/0	) 8/2016
NAME OF I	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	1 12/0	75/2010
		1717 LINI		IVE SOUTHEAST		
IALAHII	NURSING AND REHA	SAINT C	LOUD, MN 5	6304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21235	Continued From pa	ge 37	21235			
	referred to another unaware R31 had rephysician in Septem care twice. The MD facility to contact his stating he was ultimed buring interview on of nursing (DON) stinvolved in finding corefused to follow here. The facility's Medicareviewed 1/29/16, ic include the "Overall in the facility to ensure the state of the st	physician. The MD-A was not been assessed by a nber or that she was denied lared. A would have expected the m when R31 was denied care nately responsible for her care.  12/8/16, at 11:03 a.m. director atted MD-A should have been eare for R31 since he had er as her primary physician.  all Director Agreement, dentified the responsibilities to a coordination of medical care ure the adequacy and the medical services provided				
21290	The Medical Director review, and/or revise ensure appropriate being provided by provided b	THOD OF CORRECTION: or or designee could develop, se policies and procedures to resident care and services are physicians. The Medical could educate all appropriate and procedures. The Medical e could develop monitoring compliance.  R CORRECTION: 30 DAYS  O Subp. 3 A AdmissionOrders tions  y of physician evaluations.	21290			1/17/17
	A. A resident m physician at least o	y of physician evaluations. The evaluated by a series of the first series and then whenever				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:  (X3) DATE  COMP		SURVEY LETED		
			P WING		(	
		00614	B. WING		12/0	8/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY,	STATE, ZIP CODE		
TALAHI	NURSING AND REHA	R CENTER	VERSITY DR LOUD, MN 5	IIVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21290	medically necessar	y. A physician visit is it occurs within ten days after	21290			
	by: Based on interview facility failed to ensi provided at least on	ent is not met as evidenced and document review, the ure that physician visits were ace every 30 days for the first ssion for 1 of 5 residents (R31) mitted to the facility.		Completed		
	Findings include:					
		inimum data set (MDS), dated to cognitive impairment.				
	indicated she had b following a hospital diagnosis list, dated admission diagnose along with a history	narge report, dated 8/19/16, seen admitted to the facility I stay related to leg pain. R31's I 12/7/16, identified an es of cellulitis (skin infection) of diabetes with nephropathy eart failure, and chronic ary disease.	;			
	A review of physicia notes identified the	n and physician assistant (PA following:				
	assessed by her from note indicated that to her "Advanced metalling" with multiple medicates.	eceived a visit and was om her primary physician. The R31 needed monthly visits due tultiple co-morbid conditions ations" and that "Given to skilled nursing facility will re."				

C	
00614 B. WING 12/08/2	3/2016
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
TALAHI NURSING AND REHAB CENTER  1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21290 Continued From page 39 - On 10/17/16, 47 days after her last physician visit, R31 had an appointment to establish care with a different physician outside the facility. During the appointment, an assessment was completed, but the physician later declined to accept her as a patient. The physician visit did not occur within 30 days, but 47 days since her 8/31/16 initial physician visit.  During interview on 12/7/16, at 12:27 p.m. registered nurse (RN)-A stated it had been difficult to find R31 a new physician, when her primary physician wouldn't follow her anymore. RN-A stated the situation was rare that the primary physician wouldn't follow her anymore. RN-A stated to the facility, and was unaware of the facility policy. RN-A stated (R31) needed continuity in physicians so staff knew who to contact if there were medical problems.  During interview on 12/7/16, at 3:50 p.m. R31 stated she felt "Abandoned and frustrated" by the experience and "Didn't like the way things went down" referring to not being followed by a consistent physician.  During interview on 12/7/16, at 5:13 p.m. director of nursing (DON) stated it had been difficult to find a physician for R31 due to her long term status in the facility and her younger age. However, the DON didn't think R31 was without care for that long.  During interview on 12/7/16, at 5:29 p.m. medical director (MD)-A stated he was unaware R31 had not had a consistent physician while at the nursing home. It was the responsibility of the R31's primary physician to continue to care for her until she had been accepted under a new physician, but indicated he was utilimately	

Minnesota Department of Health

STATE FORM 6899 J6VE11 If continuation sheet 40 of 74

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILBING.		С	
		00614	B. WING			8/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
I TALAHINURSING AND REHAR CENTER			VERSITY DR LOUD, MN 5	IVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21290	Continued From pa	ge 40	21290			
	responsible for ove	rseeing R31's care.				
	States Bill of Rights facility would seek	e Combined Federal and s, dated 11/28/16, directed the alternate physician services to f appropriate and adequate ."				
	nursing (DON) or d medical director an physician coverage the facility. The ad could also perform	of Correction: The director of esignee could work with the d administrator to ensure is provided the residents in ministrator, DON or designee audits of resident records to ysician services had been				
	Time Period for Co days.	rrection: Twenty-one (21)				
21390	MN Rule 4658.080	0 Subp. 4 A-I Infection Control	21390			1/17/17
	control program mu procedures which p A. surveillance collection to identify residents; B. a system for control of outbreaks C. isolation and reduce risk of trans D. in-service exprevention and con E. a resident himmunization program.	and procedures. The infection ust include policies and provide for the following: based on systematic data and nosocomial infections in and sof infectious diseases; diprecautions systems to emission of infectious agents; ducation in infection trol; ealth program including an eam, a tuberculosis program as 8.0810, and policies and				

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER  TALAHI NURSING AND REHAB CENTER  TALAHI NURSING AND REHAB CENTER  TALAHI NURSING AND REHAB CENTER  SIMMARY STATEMENT OF DEFICIENCIES AINT CLOUD, MIN 56304  SUMMARY STATEMENT OF DEFICIENCIES RECALD DEFICIENCY MUST BE PRECEDED BY PULL PRETEX TAG  COMPLETE  REQULATORY OF U.SC. DICKNIPYNIS INFORMATION; TAG  CONTINUED From page 41  Procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and infection control program to include consistent tracking, trending and analysis of illnesses and infections to prevent potential spread to others. This had potential to affect all 70 residents, staff and visitors to the facility. In addition, the facility falled to ensure staff completed a dressing change with appropriate hand hygiene for 1 of 1 residents (R39) observed during wound cares.  Findings include:  A binder was provided by the director of nursing (DON) on 12/516, with different tabbed sections representing each specific month of infection control monitoring. The following information was identified:  SEPTEMBER 2016:	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE COMP	SURVEY LETED	
NAME OF PROVIDER OR SUPPLIER  TALAHI NURSING AND REHAB CENTER  TALAHI NURSING AND REHAB CENTER  SITREST ADDRESS, CITY, STATE, ZIP CODE  1717 UNIVERSITY DRIVE SQUTHEAST  SAINT CLOUD, MN 56304     Major   D					7t. Boilebiita.			
TALAHI NURSING AND REHAB CENTER   1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 53004			00614		B. WING	<del></del>	12/0	8/2016
Completed   Comp	NAME OF I	PROVIDER OR SUPPLIER						
SUMMARY STATEMENT OF DEFICIENCIES   DEFICIENCES   GACH CORRECTION SHOULD BE (GACH DEFICIENCY) MIST BE PRECEDED BY FILL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREPIX   GACH CORRECTIVE ACTION SHOULD BE (GROSS-REFERENCED TO THE APPROPRIATE DATE)	TALAHI I	NURSING AND REHA	B CENTER					
procedures of resident care practices to assist in the prevention and treatment of infections;  F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815;  G. a system for reviewing antibiotic use;  H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control.  This MN Requirement is not met as evidenced by:  Based on interview and document review, the facility failed to implement a comprehensive infection control program to include consistent tracking, trending and analysis of illnesses and infections to prevent potential spread to others. This had potential to affect all 70 residents, staff and visitors to the facility. In addition, the facility failed to ensure staff completed a dressing change with appropriate hand hygiene for 1 of 1 residents (R39) observed during wound cares.  Findings include:  A binder was provided by the director of nursing (DON) on 12/5/16, with different tabbed sections representing each specific month of infection control monitoring. The following information was identified:	PREFIX	(EACH DEFICIENCY	MUST BE PREC	CEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	_D BE	COMPLETE
An Order Listing Report dated 12/5/16, identified	21390	procedures of reside the prevention and F. the development of the practices, including defined in part 4656. G. a system for H. a system for products which affed disinfectants, antise incontinence products. I. methods for current standards of the products of the following the products which affed disinfectants, antise incontinence products. I. methods for current standards of the following the products of the following the proving tracking, trending a infection control protracking, trending a infections to prevent and visitors to the following to the following the follo	lent care practreatment of ment and impolicies and into a tuberculos 3.0815; reviewing a review and ect infection of eptics, gloves cts; and maintaining a figram to include analysis of practice in and docume lement a conformation of analysis of practice and analysis of precential spongered during ded by the direct and his erved during ded by the direct ment is pecific montained. The following is:	infections; olementation of fection control sis program as a ntibiotic use; evaluation of control, such as s, and awareness of infection control.  Let as evidenced ent review, the enprehensive ude consistent of illnesses and oread to others. O residents, staff dition, the facility a dressing ygiene for 1 of 1 g wound cares.  Let ector of nursing a tabbed sections the of infection was information was	21390			

Minnesota Department of Health

STATE FORM 6899 J6VE11 If continuation sheet 42 of 74

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED	
		00614		B. WING			C <b>08/2016</b>
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TALAHI	NURSING AND REHA	B CENTER		/ERSITY DR .OUD, MN 50	IVE SOUTHEAST 6304		
(X4) ID PREFIX TAG		TEMENT OF DEFICIE MUST BE PRECEDE SC IDENTIFYING INF	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
21390	Continued From pa	ge 42		21390			
	during the month for included a urinary to infection, pneumonous lacked any dates of room numbers, orgodetermined to be considered.  A single Employee identified an employ of, "Puking, shaky [In addition, several Services reports daidentified different of specimens. The represidents had urine same bacteria, how on the date of symplection was determine the cause of the infection determine the cause included included in the collected data analysis of the infection determine the cause infection.	ract infection, a ia, and a, "Rash is, and a, "Rash is symptom onser anisms, or if the ommunity or in-hommunity or called in ill vand] a fever."  Centracare Laboted 9/1/16, throughtures of collections identified to samples culture vever lacked any trend to be completed in the faciliary of the complete in the faciliary in the faciliar	dental ." The report t or resolution, infection was nouse  ated 9/1/16, with symptoms  oratory ugh 9/30/16, sted hree different ed with the information olution, or if the munity or  ding or lity to				
	had potential to, or	were spreading	in the facility.				
	OCTOBER 2016:						
	An Order Listing Resix residents had remonth for different of chronic pain syndrous severe sepsis. The symptom onset or room numbers, or it to be community or	eceived antibiotic diagnosis which ome, pneumonia e report lacked a resolve, organisi f the infection was in-house acquir	es during the included , yeast, and , any dates of m cultures, as determined red.				
	An undated Infectio	n Report Form i	dentified a				

Minnesota Department of Health

STATE FORM 6899 J6VE11 If continuation sheet 43 of 74

AND PLAN OF CORRECTION IDENTIFICATION NUMBER.  A. BUILDING:	
00614 B. WING 12/08/20	/004 <i>C</i>
12/00/20	2016
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  1717 UNIVERSITY DRIVE SOUTHEAST	
TALAHI NURSING AND REHAB CENTER SAINT CLOUD, MN 56304	
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COI	(X5) COMPLETE DATE
resident had an infection noted to begin on 10/27/16, and listed her name, sex and room number. The form had spacing to identify what type of infection had occurred including additional spacing to place a checkmark in corresponding symptoms. However, all of these fields were left blank and no data was entered to identify what type of infection the resident had or any symptoms which had developed.  An additional Infection Report Form identified a different resident with their name, unit and date of admission; however lacked any further information. The remainder of the form was left blank and no data was entered to identify what type of infection the resident had or any symptoms which had developed.  The collected data lacked any trending or analysis of the infections in the facility to determine the cause of each infection or if they had potential to, or were spreading in the facility.  NOVEMBER 2016:  An Order Listing Report dated 12/5/16, identified nine residents had received antibiotics during the month for different diagnosis which included urinary tract infection, bronchitis, pneumonia, and a, "Rash." The report lacked any dates of symptom onset or resolution, room numbers, organism cultures, or if the infection was determined to be community or in-house acquired.  The data lacked any trending or analysis of the infections in the facility to determine the cause of each infection or if they had potential to, or were	

Minnesota Department of Health

STATE FORM 6899 J6VE11 If continuation sheet 44 of 74

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		SURVEY PLETED
		00614	B. WING			C <b>08/2016</b>
	PROVIDER OR SUPPLIER  NURSING AND REHA	R CENTER 1717 UN	ADDRESS, CITY, S' NIVERSITY DRI CLOUD, MN 56	VE SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21390	Continued From pa	ge 44	21390			
	There was no furth of the identified mo	er information provided for an nths of data.	у			
	director of nursing had been in charge employed at the factor process of being recoversee. Further, to control program lactor trending or analysis "We have to come "Have better tracking facility]." Further, the aware the program components for the During interview on	e past couple weeks.  12/8/16, at 10:32 a.m. the	r			
	for infections during throughout the wee processes for track	d staff were, "Always watching g their regular meetings k, however do not start any ing or trending unless pattern ng noted, "I look for the				
	2/16/16, identified a "Help prevent the dof disease and infe several elements of included, "Surveilla collection," and havinvestigation, and coinfectious disease. I summaries of the intervent and analyzed by the with findings being	Control Program policy dated an objective which included, levelopment and transmission ction." The policy identified if the facility program which nce based on systemic data ving, "A system for detection, control of outbreaks of 'Further, the policy identified of fections were to be compiled to infection control committee, communicated to determine it or procedures were required.	f			

Minnesota Department of Health

STATE FORM 6899 J6VE11 If continuation sheet 45 of 74

PRINTED: 01/26/2017 FORM APPROVED

IVIInneso	<u>ita Department of He</u>	alth				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					_	
		00014	B. WING		10/0	
		00614	D. W. K		12/0	8/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		1717 LINI\	FRSITY DR	IVE SOUTHEAST		
TALAHI I	NURSING AND REHA	R CENTER	OUD, MN 50			
			OOD, MIN 30			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPRO		DATE
1710		,	ı, ı, ı	DEFICIENCY)		
21390	Continued From pa	ge 45	21390			
	HAND HYGIENE					
		inimum Data Cat (MDC) datad				
		inimum Data Set (MDS) dated				
		R39 was cognitively intact with				
		jestive heart failure and an				
		e amputation. On 10/17/16,				
	o o	ange in status MDS identified				
		eable pressure ulcer on R39's				
	left heel and anothe					
		ministration record identified a				
		11/04/16, for "Dressing				
		Clean open area with normal				
		vith Melgisorb dressing.				
		n an as needed basis."				
		on 12/07/16, licensed				
		N)-A donned a set of clean				
		ean gloves, LPN-A took off the				
	soiled bandage fror	m R39's left heel and threw it				
	in the trash. Withou	it first removing her soiled				
	gloves, LPN-A-A ob	tained a new bandage and				
	accidentally droppe	d it on the floor. She grabbed				
	the bandage off the	floor and obtained a pen from				
	her (LPN-A's) pock	et to mark a date on the				
	dressing without fire	st removing her soiled gloves.				
	With her same soile	ed gloves, LPN-A irrigated				
		sure ulcer. After irrigating				
		placed his clean heel unto				
	-	. With her same soiled gloves,				
		lean dressing over R39's left				
		oved her soiled gloves. LPN-A				
		wash her hands in R39's				
	bathroom.					
	When interviewed	on 12/07/16, at 7:33 a.m.				
		urse (LPN)-A stated she				
		ressure ulcer on R39's left				
		I-A) touched the ground and				
		rith her gloved hands. LPN-A				
		hould have not touched the				
	ned after being irrig	ated because it increased				

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 46 of 74 J6VE11

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		3) DATE SURVEY COMPLETED	
			A. BUILDING:			,	
		00614	B. WING		12/0	) 8/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
TALAHI I	NURSING AND REHA	R CENTER	/ERSITY DR OUD, MN 50	IVE SOUTHEAST 6304			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21390	R39's risk for an initi is important to do when working with was a higher risk or and an increased rid During interview on assistant director of wearing dirty gloves and increased the repressure ulcer on high When interviewed director of nursing sto wear soiled glove treatment as it could to the pressure ulcer.  A policy regarding high but not provided during storage of nursing storage of the provided during the provided during the provided during the procedures are est regarding policy and stream and infection control proprocedures are est regarding policy and stream and infection control proprocedures are est regarding policy and stream an	fection. Further, LPN-A stated in on a clean set of gloves pressure ulcers because there if "contaminating" the area isk of infection.  12/07/16, at 11:18 a.m. the incomplete i	21390				
	ensure compliance TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one					
21475	MN Rule 4658.100 General Requireme	5 Subp. 1 Social Services: ents	21475			1/17/17	
	home must have and department or prog- related social service	Il requirements. A nursing norganized social services aram to provide medically ces to each resident. A take referrals to or					

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE	SURVEY LETED
			A. BUILDING:			
		00614	B. WING		12/0	, 8/2016
NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
TALAHI I	NURSING AND REHA	RCENIER	/ERSITY DR OUD, MN 50	IVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETE DATE
21475	Continued From pa	ge 47	21475			
		side resources for a resident dditional mental health, r financial services.				
	by: Based on interview facility failed to proviservices to assist refor 1 of 1 residents primary physician. Findings include: R31's admission mit 8/26/16, indicated in	and document review, the ride the necessary social esidents in finding a physician (R31) who did not have a minimum data set (MDS), dated to cognitive impairment.		Completed		
	indicated she had be following a hospital also indicated a following a hospital also indicated a following primary physician a R31's diagnosis list identified an admissinfection) along with nephropathy (kidnechronic obstructive). Review of physiciar notes identified the On 8/31/16, R31 reassessed by her printle The note indicated visits due to her "Acconditions with multiple also indicated and the conditions with multiple also indicated and the conditions with multiple also indicated also indicated as a second transfer of the conditions with multiple also indicated also indicated as a second transfer of the conditions with multiple also indicated as a second transfer of the conditions with multiple also indicated as a second transfer of the conditions with multiple also indicated a second transfer of the conditions with multiple and the conditions with multiple and the conditions with multiple and the conditions with a second transfer of the conditions with multiple and the conditions with a second transfer of the conditions with a second transf	n and physician assistant (PA) following: ceived a visit and was mary medical doctor (MD-B). that R31 needed monthly dvanced multiple comorbid tiple medications" and that acement in skilled nursing				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	LE CONSTRUCTION		E SURVEY PLETED	
		00614	B. WING			C
		00614	B. WG		12/	08/2016
NAME OF	PROVIDER OR SUPPLIER		ADDRESS, CITY,			
TALAHI	TALAHI NURSING AND REHAB CENTER 1717 UNI SAINT CI			RIVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21475	On 10/17/16, 47 da R31 had an appoint different physician, assessed R31. The be contacting the faconcerning R31's not are." On 10/24/16, as a patient recommender, and offere facility.  On 11/3/16, 76 days an appointment with R31, the PA-A also patient due to her corecommended an literative of the commender of t	ys after her last physician vistment to establish care with MD-C outside the facility when note identified MD-C would acility to "Clarify the issue on-eligibility for in-facility, MD-C declined to take R31 mending an Internal Medicined to place referral for the safter her admission, R31 has a physician and medicine to take R31 as a complex medical history and internal Medicine Physician.  The safter she was admitted, the tender of the safter she was admitted, the tender of R31 and the safter she was admitted, and the safter she was admitted, the safter she was admitted, the safter she was admitted, and the safter she was admitted, the safter she was admitted, the safter she was admitted, and the safter she was admitted, the safter she was admitted she was admitted, the safter she was admitted she was admitted, the safter she was admitted she was admitted she was admitted, the safter she was admitted she was admitted she was admitted, the safter she was admitted she wa	a o o e ad al sat ern,			
	he would have expeservices to aide in f physician.	ected the facility's social				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DAT  A. BUILDING:			E SURVEY PLETED		
		00614	B. WING			C <b>08/2016</b>	
	NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304						
	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
work followsitual staff physical role role role role role role role rol	wed by their printion. SW-A state were working were working with a social massisting R3 and provided to medically consible personal service needs a service need to deed to medically on the could be made and service needs are deficiency, what and service needs are developed the shared with the sament & Assoning compliance.	ed residents were typically imary physician, unlike R31's ted she thought the nursing on finding R31 a new al services did not have any 1 to find a physician.  THOD OF CORRECTION: or designee, could review y policies and procedures or related social services. Innel could be re-educated on procedures. Appropriate de toward supporting the sof the individual(s) identified ith supporting documentation residents could be evaluated eeds. An auditing system if and implemented, with the facility's Quality urance committee, to ensure	t				
Subj mon unne hom phar resid phys hom	ge; Monitoring o. 2. Monitoring itor each reside ecessary drug u e's policies and macist must re dent's attending ician does not e's recommend	g. A nursing home must ent's drug regimen for usage, based on the nursing d procedures, and the port any irregularity to the physician. If the attending concur with the nursing dation, or does not provide on, and the pharmacist	21540			1/17/17	

Minnesota Department of Health

-	NT OF DEFICIENCIES OF CORRECTION		R/SUPPLIER/CLIA ATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00614		B. WING		12/0	) 8/2016
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE	1	
IALAHINURSING AND REHAR CENTER				/ERSITY DR OUD, MN 50	IVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21540	Continued From paradversely affected, matter to the medical medical director is the medical director physician does not the order and if the change the order, the review to the Qualit (QAA) committee rethe attending physician the consulting pharadirectly to the QAA.  This MN Requirement by: Based on interview facility failed to ensinterventions and becompleted prior to a medications for 1 of for unnecessary medications for 1 of the medication	the pharmace the pharmace and director for not the attending of the attending phase and attending the matter makes and docume ure non-phare administering for 5 residents administering for a seessment (Control of the phase and	r review if the ding physician. If that the attending the justification for nysician does not ust be referred for and Assessment art 4658.0070. If redical director, refer the matter are as evidenced ent review, the macological toring were anti-anxiety (R80) reviewed  Set (MDS) dated cognitive major depressive  CAA) dated aviors or re assistance of (ADL's).  indicated R80 esident uses a related to for R80 included;	21540	Completed		

Minnesota Department of Health

STATE FORM 6899 J6VE11 If continuation sheet 51 of 74

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE COMP	
		00614	B. WING		12/0	8/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TALAHI	NURSING AND REHA	R CENTER	OUD, MN 50	IVE SOUTHEAST 6304		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	(X5) COMPLETE DATE
21540	Continued From pa	ge 51	21540			
		ument per facility protocol. ation of how R80's exhibited				
	to 2:28 p.m. R80 exanxiety. During obs	on 12/6/16 between 1:45 p.m. chibited no outward signs of servation on 12/7/16 from 6:00 R80 presented no signs of				
	Review of R80's medication administration record (MAR) indicated R80 had an order for lorazepam (medication used to treat anxiety) 0.25 milligrams (mg) tablet every 6 hours as needed for anxiety disorder. Further, the order specified facility staff were to document signs of anxiety, non-pharmacological interventions used and its effectiveness before administering the medication.					
	Review of the MAR	identified the following:				
	In August 2016, R80 took her as needed lorazepam on 2 different occasions of which both episodes did not identify any signs of anxiety or non-pharmacological interventions used.					
	lorazepam on 10 di above episodes no non-pharmacologic	, R80 took her as needed fferent occasions. During the signs of anxiety, or al interventions were he use of the medication.				
	lorazepam, and sig non-pharmacologic attempted prior to t	80 received 7 doses of ns of anxiety, or al interventions were he use of the medication. ation of why the medication				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			`
		00614	B. WING		12/0	8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TALAHI	NURSING AND REHA	R CENTER	/ERSITY DR OUD, MN 56	IVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
21540	Continued From pa	ge 52	21540			
	lorazepam and sign non-pharmacologic	R80 took 6 doses of anxiety, or all interventions were he administration of the				
	on 01/20/16, the co indicated facility sta behaviors, non-pha attempted and effectiorazepam. On 11/ the documentation	armacist drug regimen review insultant pharmacist (CP) aff needed to document irmacological approaches ctiveness for R80's as needed 14/16, the CP again indicated on R80's lorazepam needed s and non-pharmacological				
	During interview on 12/07/16 at 10:19 a.m. registered nurse (RN)-D stated facility staff were expected to document non-pharmacological interventions and behaviors prior to administering the as needed lorazepam. Further, RN-D stated there was no behavior monitoring or non-pharmacological interventions attempted after reviewing R80's medical record.					
	nursing (DON) state staff to document n interventions and b effectiveness of the	on 12/07/16, the director of ed it was important for facility on-pharmacological ehaviors "to evaluate" the e as needed lorazepam. There e use of this medication at the 60.				
	"Psychotropic Medi identified all anti-an to residents require	bjectively" document				

6899

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00014		B. WING		)	
		00614	I.		12/0	8/2016	
	PROVIDER OR SUPPLIER	1717 IINI\		STATE, ZIP CODE IVE SOUTHEAST			
IAI AHI NURSING AND REHAB CENTER			OUD, MN 50				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21540	Continued From pa	ge 53	21540				
	The director of nursidevelop and impler to ensure that residunnecessary medicinclude parameters staff. The DON or omnitoring systems compliance and repassurance Commit	ations, ensure all medications, and educate all relevant designee can develop to ensure ongoing port the findings to the Quality					
21550	MN Rule 4658.132 Medications; Pharn	5 Subp. 1 Adminiatration of nacy Serv.	21550			1/17/17	
	Subpart 1. Pharmacy services. A nursing home must arrange for the provision of pharmacy services.						
	by: Based on observation review, the facility of solution was availal and were not expired 3 of 9 residents (RS) received the expired facility failed to ensuccording to manufaction residents (R94).  Findings include:  EXPIRED TUBERO	ent is not met as evidenced on, interview, and document ailed to ensure tuberculin ble for resident and staff use ed. This had potential to affect 04, R93 and R98) who disolution. In addition, the ure medications were given actures instructions for 1 of 1		Completed			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00614	B. WING		12/0	) 8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
TALAHI	NURSING AND REHA	R CENTER	/ERSITY DR OUD, MN 56	IVE SOUTHEAST 5304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21550	storage room was of (RN)-D. The West is contained an opened Purified Protein Derivated to test for expexpiration date of 1 RN-D stated the tuber for residents and fastated expired TB sadministered after the could cause an "inated described to the could described to the could describe to the could describe the medication of the could describe the could desc	observed with registered nurse medication storage refrigerator of package of Tuberculin rivative (TB) (a medication osure to Tuberculosis) with an 0/10/16, written on the vial. Derculin solution was available cility staff. Further, RN-D olution should not be he expiration date because it accurate result."  umentation titled, "Baseline cursing home and boarding given an expired TB test (lot in 12/1/16, 21 days after it iven expired TB solution (lot in 11/22/16, 12 days after it as administered TB test (lot in 11/21/16, 11 days after it in 11	21550			

6899

-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00614	B. WING			)8/ <b>2016</b>
	PROVIDER OR SUPPLIER NURSING AND REHA	B CENTER 1717 UNIV		TATE, ZIP CODE VE SOUTHEAST 304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21550	A facility policy on e	ge 55 xpiration dates for TB solution was not provided during the	21550			
	12/1/16, indicated F and aspiration and mouth (NPO). R94	SUIDELINES: sident Care Plan dated R94 was at risk for choking was to receive nothing by 's Admission Record face had a malignant neoplasm of				
	dated 12/1/16, indic (difficulty swallowing (percutaneous endorplaced in abdomina nutrition, fluids and/ into the stomach, b esophagus) tube p receive myrbetriq (roveractive bladder) release (designed t	mmary from Mayo Clinic sated R94 had dysphagia g) and had a peg oscopic gastrostomy, which is all wall and stomach to allow for medications to put directly ypassing the mouth and laced. Further, R94 was to medication for treatment of 25 milligrams (mg) sustained or release medication in body riod of time) by mouth every				
	12/02/16, indicated	ST) Plan Of Care, dated R94 was unable to swallow ad no spontaneous swallow				
	listened practical numedications. LPN-medications except stated the medication and could not be cr	12/07/16, at 10:40 a.m. urse (LPN)- D set up R94's A crushed all of R94's for THE myrbetriq. LPN-D on was "sustained released" ushed, and was ordered to be PN-D entered R94's room and				

Minnesota Department of Health

STATE FORM 6899 J6VE11 If continuation sheet 56 of 74

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED
		00614	B. WING			C <b>08/2016</b>
	PROVIDER OR SUPPLIER	B CENTER 1717 UNIV		STATE, ZIP CODE IVE SOUTHEAST 5304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21550	administered R94's myrbetriq, via peg t would not be able to she was uncertain in During interview 12 stated she spoke we discontinued myrbethad received the madmission, but was administered this madministered this madministered this madministering it stated the nurses swith R94's physician During a subsequent 9:21 a.m. LPN-D stated the nurses swith R94's physician During a subsequent 9:21 a.m. LPN-D stated the nurse swith R94's physician During a subsequent stated the nurse swith R94's physician During a subsequent stated the nurse swith R94's physician During a subsequent 9:21 a.m. LPN-D stated the nurse swith R94's physician During a subsequent stated the nurse swith R94's phys	medications, except ube. LPN-A then stated she o give R94 myrbetriq because f R94 could swallow the pill.  /07/16, at 1:00 p.m. LPN-D ith R94's physician who etriq. LPN-D also stated R94 yrbetriq five times since uncertain how the staff nedication to R94.  /08/16, at 9:15 a.m. the fDON) stated the staff must be myrbetriq by crushing it, t via the peg tube. The DON hould have clarified this order n.  Int interview on 12/08/16, at ated she had given R94 ng it and giving it via R94's  se requested on giving ling to manufacture was not received.  In from the manufacture S, Inc. revised August 2016, 'You should take Mybetriq with the tablet whole. Do not crush	21550			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES OF CORRECTION		R/SUPPLIER/CLIA ATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				A. BUILDING.			,
		00614		B. WING			8/2016
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TALAHI	NURSING AND REHA	B CENTER		/ERSITY DR OUD, MN 5	IVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21550	Continued From parecommendations. develop monitoring compliance and reparecompliance Commit TIME PERIOD FOR (21) days.	The DON o systems to e port the findin tee.	ensure ongoing gs to the Quality	21550			
21705	MN Rule 4658.1418 Housekeeping, Ope Subp. 6. Heating, a ventilation. A nurs maintain the mecha comfortable and sa and humidity levels areas must be main C:	eration, & Ma air conditioning ing home mu- anical system fe temperature tained accor- ction of a new maintain a te enheit to 81 cones. facilities, a nu- inimum temp to during the half the temperature allowed if the ted resident provided ervices necessatures 2 of 5 one or three rations and the facility	intenance  ig, and st operate and s to provide res, air changes, es in all resident ding to items A to r physical plant, a emperature range degrees  ursing home erature of 71 eating season. res required by variations are preferences. et as evidenced and document de housekeeping essary to maintain resident resident resident resident resident resident resident	21705	Completed		1/17/17

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/S IDENTIFICATI	UPPLIER/CLIA ON NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY
		00614		B. WING		12/0	C 0 <b>8/2016</b>
	PROVIDER OR SUPPLIER	B CENTER	1717 UNI		STATE, ZIP CODE IVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIES OF THE APPR	ULD BE	(X5) COMPLETE DATE
21705	Continued From pa	ge 58		21705			
	areas.						
	Findings include:						
	During observation environmental tour with maintenance s the following finding	of the facility was upervisor (MS)	as conducted				
	The resident dayroodining room, was comeasured at 66 dec	ool. The temper	rature				
	In R162, the tempe at 70 degrees F.	rature in the roo	om measured				
	In R167 the temper 66 degrees F.	ature in the roo	m measured at				
	On 12/08/16, at 1:0 findings listed abov practice was for fact with concerns with up in the morning a maintenance staff. checked resident of temperatures in over "have time," and was to it.	e. MS stated the cility staff to noting the paper slips, which as needed by the further, MS state ar common area ar a month becarter.	e usual facility fy maintenance ich were picked by the uted he had not room ause he did not				
	A policy on facility nobut was not provide						
	Suggested Method facility operations (I could work with the policies and proced for the resident room monitor resident room or designee could p	DOF) operation administrator flures for when to ms, and ensured the ms, temperature	s or designee to update o regulate heat a a process to es. The DON				

Minnesota Department of Health

STATE FORM 6899 J6VE11 If continuation sheet 59 of 74

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION		SURVEY PLETED
		00614	B. WING			C <b>08/2016</b>
	PROVIDER OR SUPPLIER	R CENTER 1717 U		STATE, ZIP CODE RIVE SOUTHEAST 6304	·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
21705	rooms to determine adequate.	ge 59 if the temperature is rrection: Fourteen (14) days.	21705			
21800	Residents of HC Farsubd. 4. Informat residents shall, at a are legal rights for stay at the facility of treatment and main that these are described written statement of responsibilities set case of patients adress defined in section statement shall also person 16 years old provided in section shall list the names individuals and organ advocacy and legal residential program accommodations slocal health authorit the written statement to patients, resident to the administrator person, consistent to	tion about rights. Patients ard dmission, be told that there their protection during their rethroughout their course of tenance in the community arribed in an accompanying of the applicable rights and forth in this section. In the mitted to residential program in 253C.01, the written of describe the right of a distribution of a distribution of the request release a 253B.04, subdivision 2, and and telephone numbers of anizations that provide services for patients in	nd s as			1/17/17

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUP IDENTIFICATION		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMPI	
		00614		B. WING		10/0	
		00614		D. W. C		12/0	8/2016
NAME OF I	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
TALAHI	NURSING AND REHA	B CENTER		/ERSITY DR .OUD, MN 50	IVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIEN MUST BE PRECEDED SC IDENTIFYING INFO	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21800	Continued From pa	ge 60		21800			
	This MN Requirements by: Based on interview facility failed to provinctice to 2 of 6 residuho were discharge	and document re ride the appropria dents (R64 and F	eview, the te liability 191) reviewed		Completed		
	Findings include:						
	R64's admission Mi 10/28/16, indicated occupation therapy	he received phys	ical and				
	R64's was provided Medicare Non-Cove explains a resident's through the QIO or Organization on 11/services where end discharged from the received notice form Straits Health as the received the form C 10095, which was the	erage CMS 10095 is right to an immore Quality Improven 4/16, identifying hing on 11/7/16. For facility on 11/8/1 in CMS 10095, where QIO. R64 should should be the control of the control	5 (which ediate appeal nent nis Medicare R64 was 6. R64's nich identified lid have not the CMS				
	R91's admission MI he received physica while a resident in t resident at the facili	al and occupation he facility. R91 w	therapy				
	R91 received and s 10095 on 11/22/16, ending on 11/24/16, facility, he also rece on continued stay (v financial obligations end). R91 should ha 10123, and not the incorrect form.	regarding Medica Since R91 remeived the a SNF downlich explains a when Medicare ave received the	are services ained in the etermination resident's services form CMS				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/	SUPPLIER/CLIA TION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				A. BUILDING.			,
		00614		B. WING			8/2016
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TALAHI I	NURSING AND REHA	B CENTER		/ERSITY DR OUD, MN 50	IVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21800	Continued From pa	ge 61		21800			
	During interview on business office staf 10095 was form sh issue. BOS stated difference between 10123, and did not was. BOS stated s them" when deliver residents.	f (BOS) stated e had been ins she was unaw forms CMS 10 know who the he "never real	I the form CMS structed to vare of any 0095 and CMS facility's QIO ly looked at				
	During interview on of nursing (DON) st difference in forms nor who the facility	tated she was CMS 10095 a	unaware of the nd CMS 10123,				
	Review of the CMS 10095 form, expired ago.						
	SUGGESTED MET The administrator of review, and/or revise ensure staff are ediliability notices to produce to produce to produce the services, are communicated. The administrator of appropriate staff on and develop a monongoing compliance.	or designee control des	uld develop, procedures to appropriate ts at the end of resident rights and acted upon. uld educate all nd procedures				
	TIME PERIOD FOR (21) Days	R CORRECTION	ON: Twenty-one				
21855	MN St. Statute 144 Residents of HC Fa			21855			1/17/17
	Subd. 15. Treatm	nent privacy. F	Patients and				

STATEMENT OF DEF AND PLAN OF CORR			R/SUPPLIER/CLIA CATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMPI	
		00614		B. WING		12/0	; 8/2016
NAME OF PROVIDER		B CENTER	1717 UNI	, ,	STATE, ZIP CODE IVE SOUTHEAST 6304		
	CH DEFICIENC	ATEMENT OF DEI Y MUST BE PREC SC IDENTIFYING		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
resider and pri person consult confide Privacy bathing except assista  This M by: Based review, privacy (R94) vactivitie  Finding  R94's A had de individual indicate dressir  During was lying R94 was gown or bare bar product hallway Numer room, I	vacy as it real care progration, examential and shown as needed for as needed for as needed for as needed for as provided by the facility of t	e the right to lates to their ram. Case dination, and tall be conducted during activities of properties of propert	liscussion, reatment are cted discreetly. In the steed discreetly. In the steed discreetly. In the steed discreetly are sonal hygiene, resident safety or cet as evidenced are as evidenced are as evidenced are 1 of 5 residents in staff for ced, indicated R94 and disease. The cated 12/1/16, stance with ced, exposing her incontinent cetely open to the	21855	Completed		

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00614	B. WING		12/0	) 8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	STATE, ZIP CODE		0 0 . 0
ΤΔΙ ΔΗΙ	NURSING AND REHA	R CENTER	_	IVE SOUTHEAST		
		SAINI C	LOUD, MN 50			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
21855	Continued From pa	ge 63	21855			
	around" and must h	N)-A stated R94 "fidgets nave pulled off her sheets. I should not have been left rs to see.				
	was lying in bed, wi open, exposing her incontinent product exposed the top of R94's room, and an administering medic just outside of R94's	12/06/16, at 7:55 a.m., R94 th the room door completely back side. R94 wore an which had fallen down and her buttocks. Staff walked by unidentified nurse was cation from the cart parked s room. Staff made no 194, or close her door to anal privacy.				
	director of nursing ( have provided priva covered. The DON	/08/16, at 9:31 a.m. the (DON), stated staff should acy and attempted to keep R94 stated the facility will be ang the staff on privacy.	E			
	A policy was reques provided.	sted for privacy and was not				
	The Director of Nur could develop, revie procedures to ensu maintained. The Director designee could eduthe policies and pro	HOD OF CORRECTION: sing Services or designee ew, and/or revise policies and re all residents' privacy is rector of Nursing Services or locate all appropriate staff on ocedures. The Director of redesignee could develop to ensure ongoing				
	TIME PERIOD FOF Twenty-One (21) da					

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00614	B. WING		12/0	8/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TALAHI I	NURSING AND REHA	RCENIER	/ERSITY DR OUD, MN 50	IVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
21870	Continued From pa	ge 64	21870			
21870	MN St. Statute 144 Residents of HC Fa	.651 Subd. 18 Patients & ac.Bill of Rights	21870			1/17/17
	residents shall have	nsive service. Patients and ethe right to a prompt and se to their questions and				
	by: Based on interview facility failed to add to have the adminis council meetings, w	ent is not met as evidenced, and document review, the ress a resident council request strator or DON present during which had the potential to affect 13, R65, R6, R53, R48 and council meetings.		Completed		
	Findings include:					
	9/11/16, identified in indicated R13 was	imum Data Set (MDS) dated ntact cognition. The MDS also usually understood when nd could make her needs				
	cognitive impairme	S dated 11/19/16, indicated nt. The MDS also indicated d when expressing ideas and eds known.				
	intact cognition. Th	dated 10/25/16, indicated the MDS also indicated R6 was expressing ideas and could bown.				
	moderate cognition indicated R53 was	S dated 9/6/12, indicated impairment. The MDS also usually understood when nd could make her needs				

Minnesota Department of Health

STATE FORM 6899 J6VE11 If continuation sheet 65 of 74

-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMF	SURVEY
		00614	B. WING			C 0 <b>8/2016</b>
NAME OF		1		STATE, ZIP CODE	12/0	JO/2010
	PROVIDER OR SUPPLIER	1717 UN		RIVE SOUTHEAST		
TALAHI	NURSING AND REHA	AR CENTER	LOUD, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21870	Continued From pa	age 65	21870			
	known.					
	cognitive impairme R48 was understoo could make her ne R30's quarterly MD cognition. The MD	OS dated 9/3/16 indicated intactors also indicated R30 was expressing ideas and could				
	stated she attender meetings. During the was a suggestion or the DON (director meetings. R13 standards and the partake in added they wouldned they would t	In 12/6/16, at 3:23 p.m. R13 d the resident council the September meeting, there made to have the administrator or of nursing) present at the stated it was "frustrating" not not there, and would be nice just nce. R13 stated she would not the meeting process, and "t have to stay the whole time. If be nice "just to hear us guys of recall seeing the DON or the ent at either the September or ouncil meeting.  The entire minutes from June, the entire minutes	e			
		incil meeting minutes dated indicated the residents				

00614 B. WING C 12/08/2016	
	00614
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	JPPLIER
TALAHI NURSING AND REHAB CENTER  1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304	REHAB CENTER
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X: PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	FICIENCY MUST BE PRECEDED BY
suggestion was now "old business." The meeting minutes identified residents who attended the meeting, as well as staff who attended, which included the social worker and activities assistant. There was no indication the administrator, director of nursing or dietary was present at the October meeting, the month following the resident council's request. The minutes indicated the activities director and social worker were the only staff present during the months reviewed. There were no meeting minutes found for November 2016.  During an interview on 12/6/16, at 3:30 p.m. R65 stated she was at the September resident council meeting, and stated residents wanted "a higher up" at the meeting, instead of just the normal staff. R65 also stated while it is good to have the "peons" there, it would be good to have the DON and administrator present. R65 said "I have never seen" those people at the meetings.  In an interview on 12/6/16, at 3:34 p.m. R6 stated he frequently attended council meetings and expected "honest input" to any question given by the resident, and then "carry through with it afterwards." R6 stated he occasionally saw the administrator in the dining area, but it would be good to have the administrator in the dining area, but it would be good to have the administrator present at the meetings.  In an interview on 12/7/16, at 12:32 p.m., social worker (SW) stated she and the activities director (AD) assisted in facilitating resident council meetings. The SW stated they tried to accommodate having various staff at the meeting for the residents, but typically "the administrator and DON" did not attend. The SW stated she did not know why the residents' request was not passed on, and "the ball got dropped." The SW	vas now "old business." The notified residents who attended well as staff who attended, a social worker and activities or indication the administrate ursing or dietary was presenting, the month following the puest. The minutes indicated ector and social worker were during the months reviewed the tries of the social worker were eting minutes found for November 12/6/16, at 3:30 personal the September residents wanted "a seeting, instead of just the notal so stated while it is good to e, it would be good to have trator present. R65 said "I he those people at the meeting worm of 12/6/16, at 3:34 p.m. by attended council meetings onest input" to any question and then "carry through with R6 stated he occasionally are in the dining area, but it was the administrator present and the activities of in facilitating resident countries. By stated she and the activities of in facilitating resident countries. We stated they tried to the having various staff at the ents, but typically "the administrator presents" the sw stated they tried to the theory typically "the SW stated they tried to the theory typically "the SW stated they tried to the theory typically "the SW stated they tried to the theory typically "the SW stated they tried to the theory typically "the SW stated they tried to the sw stated they tried to

Minnesota Department of Health

STATE FORM 6899 J6VE11 If continuation sheet 67 of 74

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			С
		00614	B. WING			08/2016
NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	STATE, ZIP CODE		
TALAHI	NURSING AND REHA	R CENTER	NIVERSITY DR CLOUD, MN 50	IVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
	administrator, the I meetings. Further, resident council me be present to discu come. The SW state council meetings have been supported by the council meeting informed of the council meeting request. The DON "invited" to the counstated she is alway units, on a daily bas another way for reswhat their needs and A facility policy, "Ref 5/23/2014, indicate sense of belonging making among the	n 12/7/16, at 3:57 p.m., the (DON) stated she was not uncil's request, nor received g minutes to read about their thought she had to be ncil meeting. Further, the DOI is talking with residents on the sidents, and staff, to talk aboute.  esident Council", revised and community decision residents," and would	N e ut a			
	grievances that hey suggestion on what further indicated gr meeting should be department," and the addressed "at the removement of the administrator, could provide staff and procedure for the resolution.	s with the opportunity to air all y may have and to give they would like." The policilievances aided during the "addressed within the proper that any follow-up can be next Resident Council.  THOD OF CORRECTION: director of nursing or designed education relating to policy resident grievance and R CORRECTION: Twenty Or	ee			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED				
		00614		B. WING		12/0	) 8/2016		
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS. CITY. S	STATE, ZIP CODE	1 12/0	.0,2010		
_	TALAHI NURSING AND REHAB CENTER  1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304								
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		EIENCIES DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDERICIENCY)	D BE	(X5) COMPLETE DATE		
21942	MN St. Statute 144. Resident and Famil Resident advisory oboarding care home advisory council and fewer than three per participating. If one function, the nursing home shall docume council or councils year. This subdivision residents and familia 144.651, subdivision	councils council. Each new shall established a family countries or both councing home or board its attempts at least once each does not alter provided by n 27.	ursing home or h a resident hair, unless an interest in ls do not reding care to establish the ach calendar er the rights of a section	21942			1/17/17		
	This MN Requirements: Based on interview facility failed to estate nursing facility this is 70 residents who residents include:  A review of document team indicated the afamily council. A "Family Interest Grogive family and frier affect their loved or indicate a meeting with agenda items.  In an interview on 1 facility administrato was discussed on amanagement in ear administrator also side.	and document ablish a family of had the potential resided in the factorial resided in the factorial resided in the factorial residence of May 13 and 13 and 14:04 residence of the factorial residence of the fact	review, the council for the al to affect all cility.  o the survey ed to establish cople to a rose was "to decisions that er, undated, , 2015, along p.m., the amily council cility's The		Completed				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			(3) DATE SURVEY COMPLETED	
		00614		B. WING		12/0	) 8/2016
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
TALAHI I	NURSING AND REHA	B CENTER		/ERSITY DR OUD, MN 50	IVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L		DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21942	Continued From paratithe facility discuss holidays coming up after the holiday sestated we needed to we are comfortable were best invested compliance" and with make an attempt to administrator acknowledge of the back burner, but extenuating circums administrator felt the establish the counce "It was not on the counce". A review of a facility Weekly Admin (admoperating officer) Counce the words "family counce Admissions/Market provided no further establishment of a support of the words and/or tasee if a family counce the provided of the support of the words and/or tasee if a family counce the provided of the support of the words and/or tasee if a family counce the support of the words.	issed, and decide, to try to get a ason. The admonget Talahi to a get Talahi to a get Talahi to a get Talahi to a to bring the fact tuntil after the pre-establishment of 2015. The adestablishment of the insisted there stances this part ere was a better all after the holical all after the holical all, dated 11/7/20 all, dated 11/7/20 all, dated 11/7/20 and the transition of the commentation of the commen	council going ninistrator a place where int, our efforts ility "up to holidays to e council. The ovement on the dministrator, of the council on were a lot of st year. The er chances to days, and stated ar."  utline for DO (chief 2016, indicated be facility a regarding the RECTION: The I family members to a be developed.	21942			
21980	MN St. Statute 626 Maltreatment of Vu		eporting -	21980			1/17/17
	Subd. 3. Timing of reporter who has revulnerable adult is be		e that a				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00614		B. WING			C <b>08/2016</b>
					STATE, ZIP CODE IVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIE MUST BE PRECEDI SC IDENTIFYING INF	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
21980	Continued From particles or who has knowled has sustained a phyreasonably explained information to the condividual is a vulned the individual is a dreporter is not requive maltreatment of the to admission, unless (1) the individual was another facility and believe the vulneral previous facility; or (2) the reporter k that the individual is in section 626.5572 (b) A person not provisions of this sas described above (c) Nothing in this known or suspected knows or has reason been made to the condition (d) Nothing in this reporter from also reason to believe the 626.5572, subdivision. If the retime believes that a agency will determit the reported error with the criterial under section (d) the lead of the condition of the lead of the l	dge that a vulner ysical injury which a shall immedia ommon entry portable adult sole mitted to a facilitized to report sure individual that on the reporter has pole adult was made a vulnerable adult was made a vulnerable adult was made a vulnerable adult was made a required to report of the reporter of the reporter of the portable adult was made an error under the portage of th	ch is not ately report the point. If an any because y, a mandated spected occurred prior the facility from a reason to altreated in the ason to believe dult as defined y, clause (4). For the interily report a report of if the reporter a report has point. For eclude a wenforcement own or has a resection of (c), clause nder this illity, at any by a lead termine that according to y, subdivision eporter or nentry point or	21980			

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					С	
		00614	B. WING		12/0	8/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TALAHI	NURSING AND REHA	B CENTER	/ERSITY DR OUD, MN 50	IVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21980	how the event mee 626.5572, subdivisi (5). The lead ager information when mee the report under sure facility failed to ensinjuries of unknown reported to the adm (SA) and were thore residents (R97 and abuse incidents we findings include:  R97's significant chindicated she was and had no behavior 3/17/16, indicated she mental status and of the sure that the s	ts the criteria under section ion 17, paragraph (c), clause ney shall consider this naking an initial disposition of bdivision 9c.  ent is not met as evidenced and document review, the ure allegations of abuse and origin were immediately ninistrator and/or state agency oughly investigated for 2 of 5 R33) whose allegations of re reviewed.  ange MDS dated 05/18/16, severely, cognitively impaired ors. R97's care plan dated she had diagnoses of altered depression.  at Report, dated 6/9/16 at d during a bath, R97 had a five left hand that measured 6 by 4 cm, and was blue, with a 1 per in the center. The report of the had no complaints of pain she bumped it, R97 smiled was no indication the tate agency were immediately of known origin, nor was a ion completed to determine	21980	Completed		
		12/07/16, at 11:00 a.m. the unable to recall the incident.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00614	B. WING			C <b>08/2016</b>
	PROVIDER OR SUPPLIER	R CENTER 1717 UN	DDRESS, CITY, S' IVERSITY DRI' LOUD, MN 56	VE SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
21980	She thought since is smiled after being a was probably why to the administrator to cognitively impaired reported immediate then investigated.  R33's quarterly MD she was severely or care plan dated 03/impaired thought proceed the secondary to Alzheid difficulty verbalizing.  A Incident Report donursing assistant (Nourse (RN)-B that a allegedly took place 11/12/16, with an allimmediately susper rough while grabbing morning cares on 1 and two bruises we on the top of her arcm; and one on the measuring 2 cm by bruises located on measuring 2 cm by underside measure indicated the incide agency on 11/15/16 occurred. There was administrator and sontified of the incide of t	R97 nodded her head and asked if she bumped it, this he incident was not reported. hen stated if the resident is a the report should have been by reported to her, SA and  S dated 09/06/16, indicated ognitively impaired. R33's 102/15, indicated she had rocesses and cognitive status, imer's disease, and had needs.  ated 11/15/16, indicated NA)-H reported to registered a possible abuse incident eduring the morning of leged perpetrator, whom was need. NA-H reported she was not as a sexamined, re found on her left forearm, m measuring two cm by four aunderside of her arm 2 cm. There were also R33's right forearm,  4.5 cm, and the one on the left can by 2.5 cm. The report nt was reported to the state is, three days after the incident tate agency was immediately ent.				
	facility administrato	/07/16, at 11:15 a.m. the r stated the incident "should ately reported to her and the				

Minnesota Department of Health

STATE FORM 6899 J6VE11 If continuation sheet 73 of 74

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
	00614			12/0	; 8/2016
PROVIDER OR SUPPLIER	STREET ADI				0,2010
NURSING AND REHA	RCENTER				
(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETE DATE
Continued From pa	ge 73	21980			
11/15/16 to report the stated once she was immediately reported. Review of the facilit Abuse Policy and P	the incident. The administrator is notified, the incident was ed and investigated.  By Vulnerable Adult Protection, Procedure dated, 11/28/16,				
abuse must be repoimmediately. The pis unexplainable, or reported or witness neglect a report muthe Minnesota Department of the administrate also indicated an in	orted to the administrator policy further indicated if injury allegation of abuse is ed, if there is caregiver list immediately be reported to artment of Health (MDH) and or immediately. The policy ternal, facility investigation of				
The administrator, of education to facility of maltreatment to administrator or desafety and well being and education to fain neglect and injury of administrator or desamonitoring for compof maltreatment and resident safety.	or designee, could provide staff on reporting allegations the state agency. The signee could ensure residents age by providing supervision cility staff on abuse and of unknown origin. The signee could provide coliance in reporting allegations discould provide monitoring for				
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LETTER CONTINUED FROM PARTICIPATION OF LETTER CONTINUED TO A CONTINU	OGENTIFICATION NUMBER:  O0614  PROVIDER OR SUPPLIER STREET ADI  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 73  SA on 11/12/16, but a staff member waited until 11/15/16 to report the incident. The administrator stated once she was notified, the incident was immediately reported and investigated.  Review of the facility Vulnerable Adult Protection, Abuse Policy and Procedure dated, 11/28/16, indicated all allegations and/or suspicious of abuse must be reported to the administrator immediately. The policy further indicated if injury is unexplainable, or allegation of abuse is reported or witnessed, if there is caregiver neglect a report must immediately be reported to the Minnesota Department of Health (MDH) and call the administrator immediately. The policy also indicated an internal, facility investigation of reports will be completed.  SUGGESTED METHOD OF CORRECTION: The administrator, or designee, could provide education to facility staff on reporting allegations of maltreatment to the state agency. The administrator or designee could ensure residents safety and well being by providing supervision and education to facility staff on abuse and neglect and injury of unknown origin. The administrator or designee could provide monitoring for compliance in reporting allegations of maltreatment and could provide monitoring for	ORONIOR OR SUPPLIER  ORONIDER OR SUPPLIER  STREET ADDRESS, CITY, S  AINT CLOUD, MN 50  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 73  SA on 11/12/16, but a staff member waited until 11/15/16 to report the incident. The administrator stated once she was notified, the incident was immediately reported and investigated.  Review of the facility Vulnerable Adult Protection, Abuse Policy and Procedure dated, 11/28/16, indicated all allegations and/or suspicious of abuse must be reported to the administrator immediately. The policy further indicated if injury is unexplainable, or allegation of abuse is reported or witnessed, if there is caregiver neglect a report must immediately be reported to the Minnesota Department of Health (MDH) and call the administrator immediately. The policy also indicated an internal, facility investigation of reports will be completed.  SUGGESTED METHOD OF CORRECTION: The administrator, or designee, could provide education to facility staff on reporting allegations of maltreatment to the state agency. The administrator or designee could ensure residents safety and well being by providing supervision and education to facility staff on abuse and neglect and injury of unknown origin. The administrator or designee could provide monitoring for compliance in reporting allegations of maltreatment and could provide monitoring for resident safety.	OF CORRECTION    DENTIFICATION NUMBER:   B. WING	OF CORRECTION    Dentification Number:   A. Building:   COMP