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.

Summary of the facts: 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.

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

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.

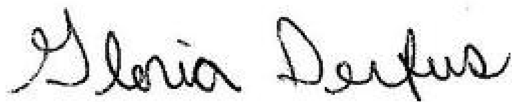
The information related to use of expired Tubersol, already appropriately addressed at F431, will be removed from the 2567 Statement of Deficiencies at F425 reducing the scope and severity of F425 to a D, isolated with potential for more than minimal harm.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245438	A. BUILDING ______ B. WING ______	12/08/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 12/5/16 to 12/8/16, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH). Talahi Nursing & Rehab Center was found to not be in compliance with the regulations at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. In addition, an investigation of complaint H5438047 was completed and substantiated with a deficiency cited at F353 during the survey. An investigation of complaint H5438046 was completed, and found to be unsubstantiated.	F 000		
F 164 SS=D	483.10(h)(1)(3)(i); 483.70(i)(2) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS 483.10 (h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. (h)(3)The resident has a right to secure and confidential personal and medical records.	F 164		1/17/17

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 01/04/2017

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

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F 164	Continued From page 1	F 164		

(i) The resident has the right to refuse the release of personal and medical records except as provided at
§483.70(i)(2) or other applicable federal or state laws.

§483.70
(i) Medical records.
(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-

(i) To the individual, or their resident representative where permitted by applicable law;

(ii) Required by Law;

(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;

(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and document review, the facility failed to ensure personal privacy was provided by staff for 1 of 5 residents (R94) who was dependent upon staff for activities of daily living.

Findings include:

F000: Preparation and/or execution of this report of correction does not constitute admission or agreement by the provider of the truth of the facts set forth in the statement of deficiencies required by the provisions of the federal and state law.

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F 164	Continued From page 2 R94's Admission Record, undated, indicated R94 had dementia and a neurological disease. The individual Resident Care Plan dated 12/1/16, indicated R94 needed staff assistance with dressing, bathing and grooming. During observation 12/05/16, at 7:09 p.m. R94 was lying in bed with her sheets pulled down. R94 was lying on her left side, with her hospital gown completely open in the back, exposing her bare back and buttocks with an incontinent product. R94's door was completely open to the hallway, as staff and visitors walked past. Numerous staff were observed walking by R94's room, but made no attempts to assist R94 to cover herself or close the door to maintain R94's privacy. During interview on 12/05/16, 7:20 p.m. licensed practical nurse (LPN)-A stated R94 "fidgets around" and must have pulled off her sheets. LPN-A stated (R94) should not have been left uncovered for others to see. During observation 12/06/16, at 7:55 a.m., R94 was lying in bed, with the room door completely open, exposing her back side. R94 wore an incontinent product, which had fallen down and exposed the top of her buttocks. Staff walked by R94's room, and an unidentified nurse was administering medication from the cart parked just outside of R94's room. Staff made no attempts to cover R94, or close her door to ensure R94's personal privacy. During interview 12/08/16, at 9:31 a.m. the director of nursing (DON), stated staff should have provided privacy and attempted to keep R94	F 164	F164- Personal Privacy of Records It is the policy of Talahi Nursing and Rehab Center provide personal privacy for its residents. The policy has been reviewed, and is accurate. R94 has been relocated to room 171-2 which is located in a low traffic area but close to the nurse's station. Staff have been re-educated on the policy to assure privacy for all residents at all times. See Exhibit 164A. Random audits will be completed three times per week for three weeks to assure privacy is protected. IDT/QAPI will evaluate outcome of these audits at the completion of three weeks and determine appropriate action to follow. See Exhibit 164B DON/designee is responsible	

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F 164	Continued From page 3 covered. The DON stated the facility will be working on educating the staff on privacy. A policy was requested for privacy and was not provided.	F 164		
F 167 SS=C	483.10(g)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 167	F167-Servey Results	1/17/17

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FORM APPROVED
OMB NO. 0938-0391

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F 167	Continued From page 4	F 167		

review, the facility failed to ensure the most recent State agency survey results were available to review. This had potential to affect all 70 residents, visitors and staff who wished to review this information.

Findings include:

During the initial tour of the facility on 12/5/16, at 11:55 a.m., a blue-colored binder labeled, "MN [Minnesota] Dept [Department] of Health Survey Results" was found on the West nursing station. The survey results contained inside were dated, 12/16/14 (nearly two years prior). There was no additional surveys identified in the binder to review.

When interviewed on 12/5/16, at 12:27 p.m. health unit coordinator (HUC)-A stated the results in the binder were not the most recently completed survey. HUC-A and the surveyor then toured the building and were unable to locate any additional survey results.

During interview on 12/5/16, at 12:29 p.m. receptionist (R)-A stated the blue binder was used to house the most recent survey results and was typically kept at the front desk.

When interviewed on 12/5/16, at 12:31 p.m. the administrator stated the blue binder was used to house the most recent survey results, "This is it," and the survey results inside were not the most current adding, "That's not the right survey." During subsequent interview on 12/5/16, at 3:29 p.m. the administrator stated the most recent survey results were placed in a different binder and accidentally put behind the front desk and was not accessible to residents or visitors.

Talahi Nursing and Rehab Center does post the results of the most recent survey of the facility in a readily accessible place for residents, family members and legal representatives of residents.

The most current survey is located on the reception desk in the front lobby, and the receptionist is responsible to assure its location on a daily basis when she is here. This was addressed immediately when pointed out by surveyor.

The receptionist maintains a calendar audit check off which confirms the survey book is located on the reception desk in the front lobby. The Administrator confirms accurate placement and maintenance of the calendar check for accurate placement of the survey book.

QAPI will review these audits at its regularly held meetings and will determine an appropriate schedule for ongoing audits

A directed in-service was conducted by the Administrator by the Regional Director of Operation on compliance and adherence to ensure the most recent survey results are available at all times.

The administrator is responsible to ensure compliance regularly.

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F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS (a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if	F 225		1/17/17

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F 225 Continued From page 6

the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

(2) Have evidence that all alleged violations are thoroughly investigated.

(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:

Based on interview and document review, the facility failed to ensure allegations of abuse and injuries of unknown origin were immediately reported to the administrator and/or state agency (SA) and were thoroughly investigated for 2 of 5 residents (R97 and R33) whose allegations of abuse incidents were reviewed.

Findings include:

R97's significant change MDS dated 05/18/16, indicated she was severely, cognitively impaired and had no behaviors. R97's care plan dated 3/17/16, indicated she had diagnoses of altered

F 225

F225- Investigate Allegations

It is the policy of Talahi Nursing and Rehab Center to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in bodily injury, or not later that 24 hours if the events that cause the allegation do not involve abuse and do not

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F 225	Continued From page 7 mental status and depression. A Risk Management Report, dated 6/9/16 at 10:20 a.m. indicated during a bath, R97 had a bruise on the top of her left hand that measured 6 centimeters (cm) by 4 cm, and was blue, with a 1 cm dark, purple area in the center. The report further indicated R97 had no complaints of pain and when asked if she bumped it, R97 smiled and nodded. There was no indication the administrator and state agency were immediately notified of the injury of known origin, nor was a thorough investigation completed to determine the possible cause of the injury. During interview on 12/07/16, at 11:00 a.m. the administrator was unable to recall the incident. She thought since R97 nodded her head and smiled after being asked if she bumped it, this was probably why the incident was not reported. The administrator then stated if the resident is cognitively impaired the report should have been reported immediately reported to her, SA and then investigated. R33's quarterly MDS dated 09/06/16, indicated she was severely cognitively impaired. R33's care plan dated 03/02/15, indicated she had impaired thought processes and cognitive status, secondary to Alzheimer's disease, and had difficulty verbalizing needs. A Incident Report dated 11/15/16, indicated nursing assistant (NA)-H reported to registered nurse (RN)-B that a possible abuse incident allegedly took place during the morning of 11/12/16, with an alleged perpetrator, whom was immediately suspended. NA-H reported she was	F 225	result in serious bodily injury, to the administrator of the facility and to other officials(including the state survey agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. The occurrences of R97 and R33 were reviewed by the IDT, and completed. The policy and procedure for vulnerable adult was reviewed and is current. All suspected vulnerable adult reports are reported to the DON and Administrator per policy guidelines. DON/Administrator or designee will complete daily audit of progress notes and risk management/incident report log to ensure update immediately of all incidents and potential VA reports. An audit tool for vulnerable adult reports was created and is in use to ensure for timely notification and completion of investigation. This tool and the findings will be reviewed weekly and the monthly QA meetings. Administrator, DON/designee are responsible	

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F 225	Continued From page 8 rough while grabbing R33 by the forearms during morning cares on 11/12/16. R33 was examined, and two bruises were found on her left forearm, on the top of her arm measuring two cm by four cm; and one on the underside of her arm measuring 2 cm by 2 cm. There were also bruises located on R33's right forearm, measuring 2 cm by 4.5 cm, and the one on the underside measured 2 cm by 2.5 cm. The report indicated the incident was reported to the state agency on 11/15/16, three days after the incident occurred. There was no indication the administrator and state agency was immediately notified of the incident. During interview 12/07/16, at 11:15 a.m. the facility administrator stated the incident "should have been" immediately reported to her and the 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.	F 225		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F 226		1/17/17

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F 226	Continued From page 9 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement their abuse prohibition policy and procedure to immediately report allegation of abuse and injuries of unknown origin to the administrator, state agency and conduct a	F 226	F226- Develop Abuse Policies It is the policy of Talahi Nursing and Rehab Center to ensure that all alleged violations involving abuse, neglect,	

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Continued From page 10

thorough investigation for 2 of 5 resident (R97 and R33) allegations that were reviewed.

Findings include:

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 to call the administrator immediately. The policy further indicated an internal facility investigation of reports will be completed.

R97's significant change MDS dated 05/18/16, indicated she was severely, cognitively impaired and had no behaviors. R97's care plan dated 3/17/16, indicated she had diagnoses of altered mental status and depression.

A Risk Management Report, dated 6/9/16 at 10:20 a.m. indicated during a bath, R97 had a bruise on the top of her left hand that measured 6 centimeters (cm) by 4 cm, and was blue, with a 1 cm dark, purple area in the center. The report further indicated R97 had no complaints of pain and when asked if she bumped it, R97 smiled and nodded. There was no indication the administrator and state agency were immediately notified of the injury of known origin, nor was a thorough investigation completed to determine the possible cause of the injury, according to the facility policy.

During interview on 12/07/16, at 11:00 a.m. the

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exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the Administrator of the facility and to other officials (including the state survey agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with state law through established procedures.

The occurrences of R97 and R33 were reviewed by the IDT, and completed.

The policy and procedure for vulnerable adult was reviewed and is current.

All suspected vulnerable adult reports are reported to the DON and Administrator per policy guidelines.

Staff have been re-educated on the vulnerable adult reporting and procedure and reporting guidelines.

DON/Administrator or designee will complete daily audit of progress notes and risk management/incident report log to ensure update immediately of all incidents and potential VA reports.

An audit tool of vulnerable adult reports was created and is in use to ensure for

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F 226	Continued From page 11 administrator was unable to recall the incident. She thought since R97 nodded her head and smiled after being asked if she bumped it, this was probably why the incident was not reported. The administrator then stated if the resident is cognitively impaired the report should have been reported immediately reported to her, SA and then investigated, as their policy identified. R33's quarterly MDS dated 09/06/16, indicated she was severely cognitively impaired. R33's care plan dated 03/02/15, indicated she had impaired thought processes and cognitive status, secondary to Alzheimer's disease, and had difficulty verbalizing needs. A Incident Report dated 11/15/16, indicated nursing assistant (NA)-H reported to registered nurse (RN)-B that a possible abuse incident allegedly took place during the morning of 11/12/16, with an alleged perpetrator, whom was immediately suspended. NA-H reported she was rough while grabbing R33 by the forearms during morning cares on 11/12/16. R33 was examined, and two bruises were found on her left forearm, on the top of her arm measuring two cm by four cm; and one on the underside of her arm measuring 2 cm by 2 cm. There were also bruises located on R33's right forearm, measuring 2 cm by 4.5 cm, and the one on the underside measured 2 cm by 2.5 cm. The report indicated the incident was reported to the state agency on 11/15/16, three days after the incident occurred. There was no indication the administrator and state agency was immediately notified of the incident, as directed by their policy. During interview 12/07/16, at 11:15 a.m. the	F 226	timely notification and completion of investigation. This tool and the findings will be reviewed weekly and at the monthly QA meetings. Administrator, DON/designee are responsible	

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F 226	Continued From page 12 facility administrator stated the incident "should have been" immediately reported to her and the SA on 11/12/16, but a staff member waited until 11/15/16 to report the incident. The administrator reported once she was notified, the incident was immediately reported and investigated, as identified by their policy.	F 226		
F 250 SS=D	483.40(d) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE (d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the necessary social services to assist residents in finding a physician for 1 of 1 residents (R31) who did not have a primary physician. Findings include: R31's admission minimum data set (MDS), dated 8/26/16, indicated no cognitive impairment. R31's hospital discharge report, dated 8/19/16, indicated she had been admitted to the facility following a hospital stay related to leg pain, which also indicated a follow up appointment with her primary physician at the facility in one week. R31's diagnosis list, dated 12/7/16, further identified an admission diagnosis of cellulitis (skin infection) along with a history of diabetes with nephropathy (kidney damage), heart failure, and chronic obstructive pulmonary disease.	F 250	F250 Provision of Medically related Social Service Talahi Nursing and Rehab Center does provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. R31 has an established physician and is followed on a regular basis by the physician. Social Service has been re-educated on their role in assisting residents to establish a primary care physician. Health Unit Coordinator maintains an audit to track date of admission and dates for required re-visits for all new admissions.	1/17/17

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F 250	Continued From page 13 Review of physician and physician assistant (PA) notes identified the following: On 8/31/16, R31 received a visit and was assessed by her primary medical doctor (MD-B). The note indicated that R31 needed monthly visits due to her "Advanced multiple comorbid conditions with multiple medications" and that "Given long-term placement in skilled nursing facility will need to transfer care." On 10/17/16, 47 days after her last physician visit, R31 had an appointment to establish care with a different physician, MD-C outside the facility who assessed R31. The note identified MD-C would be contacting the facility to "Clarify the issue concerning R31's non-eligibility for in-facility care." On 10/24/16, MD-C declined to take R31 as a patient recommending an Internal Medicine Provider, and offered to place referral for the facility. On 11/3/16, 76 days after her admission, R31 had an appointment with a PA-A. After assessing R31, the PA-A also declined to take R31 as a patient due to her complex medical history and recommended an Internal Medicine Physician. On 11/18/16, 91 days after she was admitted, R31 had an appointment with a MD-D outside the facility who completed an assessment of R31 and became her primary physician. R31's medical record lacked any indication social services was involved in assisting R31 to establish care with a primary physician while a resident at the nursing the facility. During interview on 12/7/16, at 5:29 p.m. medical	F 250	Social Services reviews audit tracker weekly to assure compliance. An audit of all residents has been completed to assure physician visits are compliant. QAPI will review this audit and make recommendations on it's continuance. Social Service, Admissions Coordinator, Health Unit Coordinator, DON are responsible.	

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F 250	Continued From page 14 director (MD)-A stated he was unaware R31 was not assessed by a physician in September or that she had subsequently been denied care twice. MD-A stated it was the responsibility of R31's primary physician to continue care until a replacement physician was found. However, after R31 was denied care from her primary physician, he would have expected the facility's social services to aide in finding R31 an appropriate physician. During interview on 12/8/16, at 11:03 a.m. social worker (SW)-A stated residents were typically followed by their primary physician, unlike R31's situation. SW-A stated she thought the nursing staff were working on finding R31 a new physician and social services did not have any role in assisting R31 to find a physician.	F 250		
F 257 SS=B	483.10(i)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS (i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81 degrees F. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide housekeeping and maintenance services necessary to maintain comfortable temperatures 2 of 5 resident rooms (R162, R165) and one or three resident dayrooms reviewed in the facility, which had the potential to affect 50 residents who used these areas. Findings include:	F 257	F257- Comfortable Temperatures Talahi Nursing and Rehab Center does maintain safe temperature levels. The windows were closed in R162 and R165 to prevent cooling of these areas. Maintenance was in-serviced to ensure proper temperatures are maintained.	1/17/17

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F 257	Continued From page 15 During observation on 12/08/16, at 12:47 p.m. an environmental tour of the facility was conducted with maintenance supervisor (MS) who confirmed the following findings: The resident dayroom, located off of the main dining room, was cool. The temperature measured at 66 degrees Fahrenheit (F). In R162, the temperature in the room measured at 70 degrees F. In R167 the temperature in the room measured at 66 degrees F. On 12/08/16, at 1:03 p.m. MS confirmed all of the findings listed above. MS stated the usual facility practice was for facility staff to notify maintenance with concerns with paper slips, which were picked up in the morning and as needed by the maintenance staff. Further, MS stated he had not checked resident or common area room temperatures in over a month because he did not "have time," and was working on getting around to it. A policy on facility maintenance was requested, but was not provided during the survey.	F 257	Maintenance will conduct audits in three random locations five times weekly for a period of three weeks, and make adjustments as indicated for temperatures outside the parameter of 71-81 degrees F. Audits will continue weekly for one more month after this period. QAPI will review audits for compliance at regularly scheduled meetings and make recommendations for continuance. Maintenance will be responsible.	
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to	F 280		1/17/17

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F 280	Continued From page 16	F 280		

be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.

(ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.

(iv) The right to receive the services and/or items included in the plan of care.

(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.

(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--

(i) Facilitate the inclusion of the resident and/or resident representative.

(ii) Include an assessment of the resident's strengths and needs.

(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.

483.21
(b) Comprehensive Care Plans

(2) A comprehensive care plan must be-

(i) Developed within 7 days after completion of the comprehensive assessment.

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F 280	Continued From page 17 (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to update the resident plan of care for falls with new interventions after a reassessment was completed for 1 of 2 residents (R92) reviewed for falls. Findings include:	F 280	F280-Right to Participate in Planning Care Plans It is the policy of Talahi Nursing and Rehab Cento to establish a care plan for all residents which accurately reflects their needs and strengths and guides staff in	

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F 280	Continued From page 18 R92's diagnoses, as identified on the face sheet dated 12/8/16, included chronic respiratory failure, anxiety disorder and weakness. R92's admission Minimum Data Set (MDS) dated 11/22/16 indicated moderately impaired cognition. The care area assessment (CAA) for falls dated 11/22/16 identified R92 was at risk for falls due to shortness of breath with activity, unsteady gait and balance. The CAA also indicated R92 was working with therapy for strengthening and endurance, was making progress, and staff were to assist with mobility and transfers. During observation on 12/06/16 at 2:22 p.m., R92 was seated in her wheel chair just outside her room door. R92 wore shoes and socks, had oxygen tubing to the right of the wheel chair, with a nasal cannula in place. Clipped to her shirt was a cord, which lead directly to a TABS (a personal, movement-detecting safety) alarm, fastened to the back of the wheel chair. Review of an Investigation Report dated 11/22/16 indicated R92 had an unwitnessed fall in her room on 11/20/16. The interdisciplinary team added an intervention to place a TABS (a personal, movement-detecting safety) alarm for R92 when in wheel chair or in bed. The care plan, revised 11/21/16, identified R92 was at high risk for falls, and directed staff to: anticipate and meet resident's needs; be sure the call light is within reach and encourage to use; encourage resident to participate in activities that promote exercise for strengthening; ensure resident is wearing appropriate footwear; follow fall protocol; and PT (physical therapy) evaluate and treat. R92's care plan lacked the TABS	F 280	providing resident care. The policy has been reviewed and is current. R92 does not have a TABS alarm. The care plan, and nurse Aide care sheets are accurate. Education was completed for direct care staff on following the care plan. All care plans are reviewed in conjunction with the RAI process. Audits of care provided, per the developed care plan, will be conducted on five random residents weekly for two months. QAPI will review audits for compliance at regularly scheduled meetings and make recommendations for continuance. DON or designee is responsible	

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F 280	Continued From page 19 alarm intervention. Review of the nursing aide care sheets, undated, identified R92 required stand by assist, was a moderate fall risk, was to bet toiled every 2 hours, and had a regular diet. The sheet did not include R92's fall intervention to use the TABS alarm. During an interview on 12/8/16 at 10:02 a.m., nursing assistant (NA)-I stated she always carried and used her nursing sheet. After reviewing the sheet, NA-I said there was nothing about R92's alarm, "but I know [R92] is supposed to have the alarm on." NA-I stated she learns of changes to residents care plans at the change of shift meetings, but it would be important to know the care plan, especially 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 care plan in the resident's chart should have been updated, as well as the aide cares sheets. The DON stated the unit managers were responsible, and it was a matter of getting that task "completed and updated." 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.	F 280		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans	F 281		1/17/17

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

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F 281	Continued From page 20 The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a care plan, sufficient to meet the needs of a newly admitted resident for 1 of 1 newly admitted residents (R94) identified at risk for pressure ulcers and skin breakdown. Findings include: R94's Admission Record, undated, indicated she had dementia and neurological disorder. The Admission Record indicated R94 was admitted to the facility on 12/01/16, and the Minimum Data Set had not been completed. A Braden Skin assessment, dated 12/01/16, indicated R94 had occasionally moist skin, was bed fast, had very limited mobility and had potential problem with friction and shear. The assessment resulted a score of 14, which indicated R94 was at moderate risk for developing a pressure ulcer. R94's Individual Resident Care Plan (a temporary care plan) dated 12/1/16, indicated she was incontinent of bowel and bladder and was toileted on rounds. The temporary care plan did not indicate or identify R94 was at risk for pressure ulcers, so interventions could be implemented to reduce R94 risk for developing pressure ulcers. During observation and interview 12/07/16, at	F 281	F281- Services Provided to Meet Professional Needs It is the policy of Talahi Nursing and Rehab Center to establish a temporary care plan within 24 hours of admission. R94 initial temporary care plan was establish on admission. This care plan was reviewed for ADL's toileting needs and repositioning needs and is current and accurate. All care plans are reviewed in conjunction with RAI process. Education completed to all direct care staff on following the care plan and implementing accurate and timely care plans. All temporary care plans have been reviewed to ensure that they meet the residents needs. Audits of care provided, per the developed care plan, will be conducted on five random residents weekly for two months. Audit of all temporary care plans to assure the temporary care plan meets the	

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F 281	Continued From page 21 8:18 a.m., NA-E stated he was checking on R94, and that she was supposed to have two staff to provide cares. NA-E stated he was going to find someone to help him. NA-E returned alone at 8:30 a.m., and said he was unable to find help. At 8:34 a.m. NA-E removed R94's incontinence pad that was moderately soaked with urine, and was incontinent of a small bowel movement. R94's entire peri- area was red and excoriated (damage or remove part of the surface of the skin). NA-E stated R94's bottom was very red, and applied peri cream to the area. NA-E then stated he started at 6:00 a.m. and this was the first time during his shift he had provided cares to R94. NA-E said he did not know when R94 was last changed. During interview 12/07/16, at 1:10 p.m., registered nurse (RN)-C stated R94 should be repositioned every two hours because "she is at risk" for skin breakdown. RN-C then stated this should have been on R94's care plan. 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 need and strengths, and guides staff in providing resident care." The policy further indicated with in 24 hours of admission, a temporary care plan will be initiated which will accurately reflect resident needs and strengths, and guides staff in providing resident care.	F 281	residents needs will be conducted for two months. Repositioning and toileting audits will be conducted on five random residents weekly for the next two months. QAPI committee will review all audits for compliance at regularly scheduled meetings and make recommendations for continuance. DON or designee is responsible	
F 282 SS=E	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility,	F 282		1/17/17

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245438	A. BUILDING ______ B. WING ______	12/08/2016

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

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F 282	Continued From page 22 as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the plan of care was implemented for 4 of 5 residents (R41, R49, R94 and R87) reviewed who were dependent on staff for activities of daily living (ADLs). Findings include: BATHING R41's quarterly Minimum Data Set (MDS) dated 11/21/16, identified R41 was moderately cognitively impaired and required total assistance from facility staff for activities of daily living (ADL)'s. In addition, R41 had no rejection of ADL's during the MDS assessment period. R41's plan of care, dated 10/06/16, noted R41 had an identified problem for ADL self-care deficit related to her (R41's) dementia. Further, the care plan identified R41 required extensive assistance of 1 with ADL's and was to receive a tub bath once a week as requested by R41. In addition, the care plan noted R41 was to be provided a sponge bath, when a full bath could not be tolerated. During an interview with R41 on 12/05/16, at 12:41 p.m. R41 stated she had not received weekly scheduled bath on a "regular basis " and was concerned because she required assistance	F 282	F282- Services Provided by Qualified Persons per Care Plan It is the policy of Talahi Nursing and Rehab Center to ensure the plan of care is followed for all residents. This policy has been reviewed and is current. R41 care plan has been reviewed and updated to reflect current receiving bed bathing needs. The nurse Aide Care Sheet is accurate. Staff re-educated on R41 bathing and documentation. A recumbent shower chair has been ordered to accommodate a full shower for R41 , and other residents as the need arises. The care plan for R49 was reviewed for dietary needs. Nurse Aide Care Sheet is accurate. R94 care plan has been reviewed and updated to reflect current turning, toileting and repositioning needs. The nurse aide care sheet has been updated.	

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F 282	Continued From page 23 from facility staff with her ADL's. R41's Body Audit Form identified R41 had 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 indication that R41 had rejected ADL's with bathing 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, but was a "tough one" to bathe. 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 according to her care plan. Further RN-D stated R41's baths,"were not happening "according to the body audit forms. During interview on 12/07/16, at 11:26 a.m. with director of nursing (DON) stated she was aware residents in the facility were not receiving their baths as directed by the care plan. ASSISIT DEVICES R49's quarterly MDS dated 10/15/16, indicated R49 was severely cognitively impaired needed supervision and set up with eating. R49's care plan dated 08/10/16, indicated, "This resident requires mechanical soft diet and cueing by staff to eat. Cut up food as needed, coffee- fill cup half full and cool with ice prior to placing at the table, coffee should be luke warm."	F 282	Staff have been re-educated on R94 turning, toileting and repositioning needs. The care plan of R87 was reviewed and updated to include direction to staff for positioning and nurse aide sheet is accurate. Staff were re-educated on following the care plan. Audits of care provided, per the developed care plan, will be conducted on five random residents weekly for two months. QAPI committee will review all audits for compliance at regularly scheduled meetings and make recommendations for continuance. DON/designee is responsible.	

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F 282	Continued From page 24 During observation 12/07/2016, at 12:34 p.m. nursing assistant (NA)-G provided R49 her lunch tray along with a cup of coffee 3/4 full. There was no ice in the coffee and visible steam was coming from the cup. During interview 12/07/16, at 12:40 p.m. NA-G stated she was not aware of any interventions they provide to keep her coffee luke warm. Review of Incident report dated 7/27/16 at 8:30 a.m., indicated R49 was given coffee prior to breakfast meal and R49 spilled coffee on her lap. Immediate interventions included: fill coffee/hot liquid half full, and add ice cubes to cool to room temperature; and signage placed by coffee carafe in east kitchen to remind of new intervention. Although R49 received a injury from hot coffee care planned interventions were not followed to prevent an additional injury. During interview 12/07/16, at 2:22 p.m. registered nurse (RN)-B stated she thought R49's coffee should be luke warm by adding water, and after looking at her care plan it should have ice placed in it. INCONTINENCE R94's Admission Record undated indicated she had dementia and neurological disease. A facility Continence Evaluation form dated 12/06/16, indicated she was incontinent of bladder, onset was unknown, unable to sit on the toileted and was not motivated to toilet. R94's Individual Resident Care Plan (temporary	F 282		

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F 282		F 282		

Continued From page 25
care plan) dated 12/1/16, indicated she was incontinent of bowel and bladder and toilet on rounds (every two hours). The care plan indicated R94 was high risk for falls, was unable to reposition herself.

R94's nursing assistant care sheet, undated, instructed staff to toilet the resident every two hours.

During continuous observation on 12/07/16, from 6:00 a.m. to 8:34 a.m. (2 hours and 34 minutes) R94 was lying in her bed on her right side with her nightgown on. There was no staff for R94 observed during this time. A 7:52 a.m. nursing assistant (NA)-E looked into R94's room and walked by. At 8:13 a.m. NA-E entered R94's room stated he was checking on R94, but did not provide R94 with any cares. At 8:34 a.m. NA-E re-entered the room and removed R94's pad which was moderately soaked with urine, and had a small bowel movement. R94's entire peri- area was red and excoriated (damage or remove part of the surface of the skin). NA-E stated her bottom was very red, and applied peri cream to the area. NA-E stated he started at 6:00 a.m. and this was the first time during his shift he had provided cares to R94. NA-E said he did not know when R94 was last changed.

During interview 12/07/16, at 1:10 p.m. registered nurse (RN)-C stated R94 was incontinent of urine and should be toileted every two hours according to her care plan.

FALL INTERVENTIONS
R87's admission Minimum Data Set (MDS), dated 10/4/16, identified R87 was mildly, cognitively

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F 282	Continued From page 26 impaired, used a wheelchair for locomotion, and was at risk for falls and dependent upon staff for activities of daily living. R87's care plan, dated 11/8/16 identified R87 at high risk for falls and included interventions for "Dycem non-slip material to remain in wheelchair at all times while resident is up in chair." R87's care plan did not direct staff to fasten the wedge cushion to the wheelchair. 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 the evening meal at 4:48 p.m., R87 was again observed seated in his wheelchair, and no Dye was present in the wheelchair. During observation on 12/8/16, at 9:09 a.m. R87 was seated in his wheelchair during breakfast, and no Dycem was observed in R87's wheelchair. During interview on 12/8/16, at 9:16 a.m. nursing assistant (NA)-F stated R87 did not have any Dycem in his wheelchair. NA-F stated she was unaware of dycem being a fall intervention, or was needed in R87's wheel chair. During interview on 12/8/16 at 11:13 a.m., the director of nursing (DON) stated fall interventions were communicated to staff daily at morning meetings. The DON further stated staff were expected to remember the interventions, and be implementing them. A policy regarding implementation of resident care plans was requested, but not provided.	F 282		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	F 312		1/17/17

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

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F 312	Continued From page 27 (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide baths and timely toileting assistance for 2 of 3 residents (R41, R94) reviewed that were dependent upon staff for activities of daily living (ADLs). Findings include: R41's quarterly Minimum Data Set (MDS) dated 11/21/16, identified R41 was moderately cognitively impaired and required total assistance for ADL's. In addition, R41 had no rejection of ADL's during the MDS assessment period. R41's plan of care dated 10/06/16, noted R41 had an identified problem for ADL self-care deficit related to her (R41's) dementia. Further, the care plan identified R41 required an extensive assistance of one with ADL's and was to receive a tub bath once a week as requested by R41. In addition, the care plan noted R41 was to be provided a sponge bath when a full bath could not be tolerated. During an interview with R41 on 12/05/16, at 12:41 p.m. R41 stated she had not received weekly scheduled baths on a "regular basis "and was concerned because she required assistance from facility staff for her ADL's. R41's Body Audit Form identified R41 had received a tub bath on 11/21/16, 11/10/16,	F 312	312-ADL Care Provided For Dependent Residents. Talahi Nursing and Rehab Center does provide residents whom are unable to carry out activities of daily living with services to maintain personal hygiene, and timely toileting assistance. R41 and R49 were assessed for and care plans reviewed for bathing and toileting needs. Education was provided to staff on following the care plan and providing care according to the care plan. Education was provided on completion of bathing sheets. Audits of care provided, per the developed care plan, will be conducted on five random residents weekly for two months. QAPI committee will review all audits for compliance at regularly scheduled meetings and make recommendations for continuance. DON/designee is responsible	

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F 312	Continued From page 28	F 312		

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 bowel and bladder and was toileted on rounds. An untitled and undated nursing assistant care

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F 312	Continued From page 29 sheet, identified R94 was to be toileted every two hours. A Continence Evaluation assessment dated 12/06/16, indicated R94 was incontinent of bladder and wore a brief. The assessment further indicted it was unknown if R94 had an urge to void and did not use the toilet. During continuous observation on 12/07/16, from 6:00 a.m. to 8:34 a.m. (2 hours and 34 minutes) R94 was lying in her bed on her right side with her nightgown on. There was no staff for R94 observed during this time. A 7:52 a.m. nursing assistant (NA)-E looked into R94's room and walked by. At 8:13 a.m. NA-E entered R94's room stated he was checking on R94, but did not provide R94 any cares. At 8:34 a.m. NA-E re-entered the room and removed R94's pad which was moderately soaked with urine, and had a small bowel movement. R94's entire peri- area was red and excoriated (damage or remove part of the surface of the skin). NA-E stated her bottom was very red, and applied peri cream to the area. NA-E stated he started at 6:00 a.m. and this was the first time during his shift he had provided cares to R94. NA-E said he did not know when R94 was last changed. During interview 12/07/16, at 1:10 p.m. RN-C stated R94 was incontinent of urine. RN-C reported (R94) was dependent upon staff and at risk for skin breakdown, and should be checked and changed every two hours.	F 312		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity -	F 314		1/17/17

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F 314	Continued From page 30 (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide timely assistance for toileting and repositioning to reduce the risk of pressure ulcer development for 1 of 3 residents (R94) identified at risk of pressure ulcers. Findings include: R94's undated Admission Record indicated R94 was admitted on 12/01/16, which included diagnoses of dementia and multiple sclerosis (A disease in which the immune system eats away at the protective covering of nerves). R94's admission Minimum Data Set (MDS) was not completed. A Braden Skin assessment (scale for predicting pressure ulcer risk) dated 12/01/16, indicated R94 had occasionally moist skin, was bed fast, had very limited mobility, with a potential problem	F 314	F314- Treatment to Prevent Pressure Sores Talahi Nursing and Rehab Center does provide care consistent with professional standards of practice to prevent pressure ulcers. R94 was comprehensively re-assessed for skin risk. R94 care plan was reviewed and is current. All residents identified as at risk for pressure ulcer development have been reviewed to assure accuracy and to ensure they are receiving appropriate care. The policy for prevention and treatment of	

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F 314	Continued From page 31 of friction and shear. The assessment had a score of 14 which indicated R94 was at moderate risk for developing a pressure ulcer. R94's Individual Resident Care Plan (temporary care plan) dated 12/1/16, indicated R94 was incontinent of bowel and bladder and was to be toileted on rounds. R94's care plan did not indicate she was at risk for pressure ulcers. During continuous observation on 12/07/16, from 6:00 a.m. to 8:34 a.m. (2 hours and 34 minutes) R94 was lying in her bed on her right side with her nightgown on. There was no staff for R94 observed during this time. At 7:52 a.m. nursing assistant (NA)-E looked into R94's room and walked by. At 8:13 a.m. NA-E entered R94's room and said he was checking on R94, but did not provide R94 any cares. At 8:34 a.m. NA-E re-entered the room and removed R94's pad which was moderately soaked with urine, and had a small bowel movement. R94's entire peri- area was red and excoriated (damage or remove part of the surface of the skin). NA-E stated her bottom was very red, and applied peri cream to the area. NA-E stated he started at 6:00 a.m. and this was the first time during his shift he had provided cares to R94. NA-E said he did not know when R94 was last changed. During interview 12/07/16, at 1:10 p.m. registered nurse (RN)-C stated R94 was incontinent of urine, and at risk for skin breakdown. She should be checked/changed every two hours and repositioned during this time. A facility policy "Prevention and Treatment of Skin Breakdown." reviewed 3/2016, directed staff to "Properly identify and assess residents who's	F 314	pressure ulcers/skin breakdown was reviewed and is current. The policy for evaluation of skin risk was reviewed and is current. Education was provided to clinical staff on the policy and procedure for prevention of pressure ulcers/skin breakdown. Audits of care provided, per developed care plan, will be conducted on five random residents weekly for two months. After which the IDT will review and make further recommendations. QAPI committee will review all audits for compliance at regularly scheduled meetings and make recommendations for continuance. DON/designee is responsible	

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F 314	Continued From page 32 clinical conditions increase the risk for impaired skin integrity, and pressure ulcers, to implement preventative measures, and to provide appropriate treatment modalities for wounds according standards of care."	F 314		
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based	F 315		1/17/17

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	245438	A. BUILDING ______ B. WING ______	12/08/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 33 on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on 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 Findings include: R38's admission Minimum Data Set (MDS) dated 08/04/16, indicated R38 was always continent of urine. The quarterly MDS dated 10/31/16, indicated R38 was frequently incontinent of urine (7 or more episodes of incontinence but at least one episode of continence). The care area assessment (CAA) dated 8/10/16, identified R38 was on a diuretic (reduces fluid), and needed assistance with toileting. Further, the CAA identified R38 did not always ask for assistance due to cognitive impairment, and staff were to toilet R38 every two hours. R38's care plan dated 08/09/16, indicated he required extensive assistance of one for toileting. A Bladder 7 Day Documentation from 7/28/16 thru 8/4/16, indicated R38 was never incontinent of urine. A subsequent bladder assessment from 10/26/16 thru 11/1/16, indicated R38 was incontinent of urine nine times, which was a change in status from his previous assessment in August 2016. The quarterly bladder assessment dated 11/1/16	F 315	F315-No catheter, Prevent UTI, Restore Bladder Talahi Nursing and Rehab Center provides appropriate treatment and services to residents to restore continence to the extent possible. The assessment tool for evaluating urinary continence has been reviewed and is current. R38 has completed a seven day reassessment for bladder continence, and the care plan and care assessment sheet have been updated to reflect the current status. Residents identified as incontinent were reviewed to ensure they are receiving accurate assessments, and appropriate services as indicated by those assessments. The bowel and bladder assessment policy and procedure has been reviewed and is current. Staff have been re-educated to the bowel and bladder assessment policy and procedure.	

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F 315	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 pad and 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. 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 possible.	F 315	The facility will complete three audits per week for three weeks on bowel and bladder assessments, and appropriate treatments and services indicated by those assessments. QAPI committee will review all audits for compliance at regularly scheduled meetings and make recommendations for continuance. DON/designee is responsible	
F 323	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT	F 323		1/17/17

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F 323 SS=E	Continued From page 35 HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate supervision and interventions were implemented to prevent accident hazards for 4 of 5 residents (R87, R49, R75, R37) reviewed for accidents. In addition, the facility failed to ensure bed rails were properly fastened and secured to the bed frame to promote safety for 1 of 20 residents (R3) who had loose bed rails.	F 323	F323 Free of Accidents Talahi Nursing and Rehab Center assures each resident receives adequate supervision to prevent accidents. R87 care plan was reviewed and is current. Fall prevention policy was reviewed and is	

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F 323	Continued From page 36 Findings include: FALLS R87's admission Minimum Data Set (MDS), dated 10/4/16, identified R87 was cognitively impaired, used a wheelchair for locomotion, and was at risk for falls. R87's admission Care Area Assessment (CAA), dated 10/10/16, identified R87 was at risk for falls 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 recieved 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 the evening meal at 4:48 p.m., R87 was again observed seated in his wheelchair, and no dycem was present in the wheelchair. During	F 323	current. R49 care plan was reviewed and is current. R75 care plan was reviewed and is current. R3 side rails were secured at time of survey, and maintenance checks these retails daily to assure they are secure. Staff were re-educated on appropriate interventions to reduce the risk of resident to resident altercations, falls and following the care plan to prevent accidents. Maintenance performs three random audits weekly for three weeks to assure side rails are secure. All beds with rails have been checked to ensure they are tightly secured. Dietary conducts three audits weekly for three weeks to assure dietary guidelines are being followed. QAPI committee will review all audits for compliance at regularly scheduled meetings and make recommendations for continuance. DON/designee, Maintenance Director, Dietary Director are responsible.	

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F 323	Continued From page 37 observation on 12/8/16, at 9:09 a.m. R87 was seated in his wheelchair during breakfast, and no dycem was observed in R87's wheelchair. During interview 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., registered nurse (RN)-C stated R87 no longer needed the dycem in his wheelchair once R87 recieved the new wheelchair cushion, which provided a non slip surface. RN-C stated the care plan had not been revised to discontinue the dycem. During interview on 12/8/16, at 10:02 a.m. occupational therapist (OT)-A stated R87 needed the dycem in his wheelchair, and his wheelchair cushion did not provide an appropriate non slip surface. During interview on 12/8/16 at 11:13 a.m., the director of nursing (DON) stated fall interventions were communicated to staff daily at morning meetings. The DON further stated staff were expected to remember the interventions, and be implementing them. A facility policy titled "Fall Prevention," dated 9/1/16, directed all new admissions to the facility would be assessed for fall risk. The fall interventions on the care plan and assessment were to be implemented. COFFEE BURN R49's quarterly MDS dated 10/15/16, indicated	F 323		

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F 323	Continued From page 38	F 323		

R49 was severely cognitively impaired, and needed supervision and set up with eating.

A Progress Note dated 7/27/16, at 11:34 a.m. indicated R49 had picked up the coffee cup, was moving cup to her mouth spilled the hot coffee on left arm and lap. Reddened area appeared on left arm approximately "5' (inches) by 2", lap was reddened area on left leg 8" by 4", right leg 7" by 3".

A Risk Management report dated 7/27/16, indicated "Client was sitting at table in dinning room for breakfast. Client was given beverages prior to getting meal. While client was waiting for breakfast client grabbed the cup, moved it toward her mouth and accidentally spilled her coffee on her left arm and lap." Writer placed intervention in place for staff to fill coffee/hot liquid containers half full and add ice cubes to cool to room temp prior to serving, signage placed in front of the coffee carafes in east kitchen to remind staff of intervention.

R49's care plan dated 08/10/16, indicated "This resident required a mechanical soft diet and cueing by staff to eat. Cut up food as needed, coffee fill cup half-full and cool with ice prior to placing at the table, coffee should be luke-warm."

During observation 12/07/2016, at 12:34 p.m., nursing assistant (NA)-G provided R49 with her lunch tray along with a cup of coffee 3/4 full. There was no ice in the coffee, and steam was observed coming from the top of the coffee cup.

During interview on 12/07/16, at 12:40 p.m. NA-G stated she was not aware of any interventions they provide to keep R49's coffee luke warm.

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F 323	Continued From page 39	F 323		

During interview on 12/07/16, at 2:22 p.m., registered nurse (RN)-B stated R49's coffee should be luke warm by adding water. RN-B then stated R49's care plan indicated ice should be placed in her cup to keep it luke warm, not water. RN-B thought that intervention for R49 had changed.

RESIDENT TO RESIDENT ALTERCATION
R75's quarterly Minimum Data Set (MDS) dated 11/5/16, indicated she was severely cognitively impaired and depressed.

R75's care plan dated 09/29/16, indicated she had a behavior of repeatedly asking for certain staff, related to dementia with behavior disturbance. The care plan directed staff to assist R75 to develop more appropriate methods of coping and interacting, and to encourage R75 to express feelings appropriately.

R37's quarterly MDS dated 11/1/16, indicated she was severely, cognitively impaired and had diagnoses which included dementia.

A progress note dated 10/12/16 at 3:58 p.m. indicated R75 was observed to hover over another resident (R37). The note indicated staff instructed R75 to stay away from the other resident's personal space, because R37 was agitated. R75 walked over and gave R37 a left sided upper body hug. R37 swung their right fist and hit R75 in the head. There were no apparent injuries. R75 was again advised to go to her room if she couldn't keep to herself. R75 did go to her room and no further behaviors were identified.

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F 323	Continued From page 40 An Incident Report dated 10/13/16, indicated that on 10/12/16, in the afternoon staff had noted R75 standing near R37, showing concern for her. Staff offered R75 reassurance and asked her to give R37 some personal space as R37 displayed some agitation towards others at this time. R37 was in Broda chair (tilting and reclining wheelchair) and R75 was ambulating using her walker. She preceded to walk up to R37 and gave her a left sided hug. R37 then proceeded to make a fist with her right hand and strike R75. Although staff offered reassurance to R75 before the altercation with R37. There was no change with interventions implemented for either resident, after R37 struck R75, to help reduce the risk of resident to resident altercations and keep both residents safe. LOOSE SIDE RAILS R3's quarterly Minimum Data Set (MDS) dated 8/11/16 identified R3 was cognitively intact and required extensive assistance with activities of daily living (ADL's). R3 had a diagnosis of severe morbid obesity and generalized muscle weakness. During observation on 12/05/16, at 3:10 p.m R3's bed was fittend with bilateral, quarter side rails, approximately 24" (inches) in length and 8" in height. The rails were fastened to bed frame, with a screw. When grasped, each rail could be moved back and forth approximately 2" from the bed frame. During interview on 12/05/16, at 3:19 p.m. with registered nurse (RN)-E stated (R3's) side rails felt "very loose" and was a safety risk for R3.	F 323		

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F 323	Continued From page 41 Further, RN-E stated R3 frequently used the side rails to assist her in sitting up in bed. When interviewed on 12/05/16, at 3:22 p.m. R3 stated the side rails had always been "very loose" and were difficult to use when they were that loose. During interview on 12/05/16, at 6:53 p.m. the registered nurse (RN)-A stated R3's side rails felt "wobbly" which placed the resident at risk for falls and may become an entrapment risk if the side rails became any looser. On 12/08/16, at 1:03 p.m. MS stated the usual facility practice was for facility staff to notify maintenance with concerns with paper slips. Further, MS stated there was no system in place for side rail maintenance. Review of policy titled, "Side Rails" dated 6/11/16 identified staff members are to assess the side rail is safe, provide education to residents and are utilized within manufacture's instructions.	F 323		
F 329 SS=D	483.45(d) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS (d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or	F 329		1/17/17

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F 329	Continued From page 42 (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure non-pharmacological interventions and behavior monitoring were completed prior to administering anti-anxiety medications for 1 of 5 residents (R80) reviewed for unnecessary medications. Findings include: R80's quarterly Minimum Data Set (MDS) dated 08/11/16, indicated R80 had no cognitive impairment with a diagnosis of major depressive and anxiety disorder. R80's Care Area Assessment (CAA) dated 11/15/16, noted R80 had no behaviors or psychosis and required extensive assistance of one with activities of daily living (ADL's). R80's care plan dated 02/23/16, indicated R80 had an identified problem of, "Resident uses anti-anxiety medications [Ativan] related to anxiety disorder." Interventions for R80 included; monitor/record occurrence for behaviors symptoms and document per facility protocol. There was no indication of how R80's exhibited her anxiety.	F 329	F329 Drug Regimen is Free from Unnecessary Drugs Talahi Nursing and Rehab Center does ensure that residents are free from unnecessary dru7ggs without adequate indications. R80 care plan was updated to include signs and symptoms of anxiety and non-pharmacological approaches to attempt prior to administration of lorazepam. The psychotropic medications use guideline policy was reviewed and updated. All residents who receive PRN psychotropic medications were reviewed to ensure non-pharmaceutical interventions are in place and attempted prior to medication administration. Audit to ensure non-pharmaceutical interventions are trialed prior to medication administration up to five random residents per week for two	

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F 329	Continued From page 43 During observation on 12/6/16 between 1:45 p.m. to 2:28 p.m. R80 exhibited no outward signs of anxiety. During observation on 12/7/16 from 6:00 a.m. to 8:30 a.m., R80 presented no signs of anxiety. 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. In September 2016, R80 took her as needed lorazepam on 10 different occasions. During the above episodes no signs of anxiety, or non-pharmacological interventions were attempted prior to the use of the medication. In October 2016, R80 received 7 doses of lorazepam, and signs of anxiety, or non-pharmacological interventions were attempted prior to the use of the medication. There was no indication of why the medication was being given. In November 2016, R80 took 6 doses of lorazepam and signs of anxiety, or non-pharmacological interventions were	F 329	months who receive PRN psychotropic medications. All staff have been re-educated to non-pharmacological interventions prior to administration of anti-anxiety medications. QAPI committee will review all audits for compliance at regularly scheduled meetings and make recommendations for continuance. DON/designee is responsible.	

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F 329	Continued From page 44 attempted prior to the administration of the medication. Review of R80's pharmacist drug regimen review on 01/20/16, the consultant pharmacist (CP) indicated facility staff needed to document behaviors, non-pharmacological approaches attempted and effectiveness for R80's as needed lorazepam. On 11/14/16, the CP again indicated the documentation on R80's lorazepam needed to include behaviors and non-pharmacological interventions. 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. When interviewed on 12/07/16, the director of nursing (DON) stated it was important for facility staff to document non-pharmacological interventions and behaviors "to evaluate" the effectiveness of the as needed lorazepam. There is no rational for the use of this medication at the current dose for R80. Review of an undated facility policy titled, "Psychotropic Medication Use Guidelines", identified all anti-anxiety medication administered to residents required facility staff to " quantitatively and objectively" document behaviors symptoms.	F 329		
F 353 SS=E	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS	F 353		1/17/17

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245438	A. BUILDING ______ B. WING ______	12/08/2016

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

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

The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).
[As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)]

(a) Sufficient Staff.
(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:

(i) Except when waived under paragraph (e) of this section, licensed nurses; and

(ii) Other nursing personnel, including but not limited to nurse aides.

(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.

(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill

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F 353	Continued From page 46 sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. (a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide sufficient nursing staff to meet assessed resident needs for 4 of 5 residents (R41, R49, R94 and R87) reviewed for activities of daily living, 1 of 3 residents (R94) reviewed for pressure ulcers, and for 4 of 4 residents (R3, R50, R80, R20) and 10 of 10 staff members (NA-A, NA-C, NA-B, TMA-A, NA-D, LPN-C, SM-A, SM-B, SM-B, RN-A) who voiced concerns with the lack of sufficient nursing staff in the facility. Findings include: ASSESSED RESIDENT NEEDS NOT BEING MET: See F282: The facility failed to ensure the plan of care was implemented for 4 of 5 residents (R41, R49, R94 and R87) reviewed who were dependent on staff for activities of daily living (ADLs). See F312: The facility failed to provide baths and timely toileting assistance for 2 of 3 residents (R41, R94) reviewed that were dependent upon staff for activities of daily living (ADLs). See F314: The facility failed to provide timely	F 353	F353- Sufficient 24 hour Nursing Staff Per Care Plans Talahi Nursing and Rehab Center assures sufficient staff to meet the needs of its residents. Community meetings were held with the residents in regards to their needs. Meetings were held with staff to determine the most appropriate allocation of hours. Review of call light response times to determine trends or patterns. Call light policy and procedure reviewed and is current. Information in regards to staffing procedures was communicated at Resident Council. Staffing information was shared at staff meeting. Staff re-educated to call light policy and procedure.	

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assistance for toileting and repositioning to reduce the risk of pressure ulcer development for 1 of 3 residents (R94) identified at risk of pressure ulcers.

RESIDENT CONCERNS WITH LACK OF STAFFING:

R3's quarterly Minimum Data Set (MDS) dated 8/23/16, identified R3 had intact cognition and required extensive assistance with ADLs.

During interview on 12/5/16, at 3:12 p.m. R3 stated the facility lacked sufficient nursing staff to meet her needs timely. R3 stated the nursing staff were getting, "Sloppy on cares," because they had to rush through them due to not having enough staff. R3 stated she was incontinent of urine that same day because she didn't get help with toileting quickly enough adding it made her feel, "Upset and furious."

R3's Device Activity Report dated 11/24/16 to 12/8/16, identified the following call light response times:
- On 11/25/16, at 11:27 a.m. the call light was on for 22 minutes and 17 seconds;
- On 11/25/16, at 1:46 a.m. the call light was on for 43 minutes and 35 seconds;
- On 11/27/16, at 1:00 p.m. the call light was on for 18 minutes and 15 seconds;
- On 11/28/16, at 7:58 a.m. the call light was on for 16 minutes and 25 seconds;
- On 11/30/16, at 11:39 a.m. the call light was on for 15 minutes and 14 seconds;
- On 11/30/16, at 6:52 p.m. the call light was on for 21 minutes and 8 seconds;
- On 12/2/16, at 8:37 a.m. the call light was on for

Education provided to direct care staff regarding best practice for toileting and bathing.

Audits of staff and resident interviews will be conducted weekly in regards to staffing and meeting resident's needs.

QAPI committee will review all audits for compliance at regularly scheduled meetings and make recommendations for continuance.

DON/designee, Human Resources are responsible.

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F 353	Continued From page 48 59 minutes and 20 seconds and; - On 12/2/16, at 12:35 a.m. the bathroom call light was on for 47 minutes and 45 seconds. R50's quarterly MDS dated 9/20/16, identified R50 had intact cognition and required extensive assistance with his activities of daily living (ADLs). During interview on 12/5/16, at 2:10 p.m. R50 stated the facility needed more staff to completed resident care. R50 stated he needs help to use the bathroom and, at times, has come, "Pretty close" to having incontinence because there is not enough staff to assist him promptly. R50's Device Activity Report dated 11/24/16 to 12/8/16, identified the following call light response times: - On 11/30/16, at 2:01 a.m. the call light was on for 23 minutes and 32 seconds; - On 11/30/16, at 11:42 a.m. the call light was on for 19 minutes and 28 seconds; - On 12/7/16, at 3:03 a.m. the call light was on for 16 minutes and 32 seconds and; - On 12/7/16, at 7:13 a.m. the call light was on for 20 minutes and 41 seconds. R80's annual MDS dated 11/15/16, identified R80 had intact cognition and required extensive assistance with ADLs. During interview on 12/5/16, at 2:30 p.m. R80 stated the facility was not adequately staffed. R80 stated she had waited up to 30 minutes for assistance before and at times just has to, "Hang on," to her bladder so she doesn't have incontinence.	F 353		

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R80's Device Activity Report dated 11/24/16 to 12/8/16, identified the following call light response times:
- On 11/30/16, at 6:52 p.m. the call light was on for 22 minutes and 7 seconds;
- On 12/7/16, at 7:10 a.m. the call light was on for 18 minutes and 41 seconds and;
- On 12/7/16, at 11:36 a.m. the call light was on for 16 minutes and 54 seconds.

R20's quarterly Minimum Data Set (MDS) dated 10/6/16, identified R20 had moderate cognitive impairment.

During interview on 12/5/16, at 6:11 p.m. R20 stated the facility did not have enough staff to provide timely assistance with his needs. R20 stated he often has to wait up to 15 minutes for help, even after already asking for assistance. Further, R20 stated he had fallen in the hallway before and it took several minutes before staff responded to help him.

STAFF CONCERNS WITH LACK OF STAFFING:

During interview on 12/6/16, at 2:06 p.m. nursing assistant (NA)-A stated the facility is typically short staffed, "A couple times a week," and residents become upset their cares are not completed in a timely manner adding, "They [residents] can sense it." NA-A stated the resident baths are not always completed if they are short staffed and staff run around the facility, "Like chickens with their heads cut off," trying to get cares completed.

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When interviewed on 12/6/16, at 2:28 p.m. NA-C stated the nursing staff was, "Really short," some days and being full staffed with four aides on the main unit of the facility was not consistently happening anymore adding, "We're lucky if we get four aides." NA-C stated it was difficult to complete all of the assigned cares for residents, like bathing, because of the lack of staffing. NA-C stated the residents, "Get really upset," when their baths and cares aren't completed. Further, NA-C stated several staff had reported the concerns with lack of sufficient staff to the nurse managers and administration of the facility, however, staff are just told, "We're working on it."

During interview on 12/6/16, at 2:45 p.m. NA-B stated the memory care unit is typically staff with just two NA staff and a cart nurse. NA-B stated the memory care unit used to be staffed with three NA staff though, however, it was changed because administration felt people were just, "Standing around down here." NA-B stated two NA staff was not enough to care for the residents adequately or safely, "You need to have three aides because of the behaviors we have." NA-B stated resident care was suffering as a result of the lack of sufficient staffing adding, "They're [resident] not getting bathed," consistently. Further, NA-B stated these concerns regarding the lack of staff had been, "Voiced strongly," to managers and administration.

When interviewed on 12/6/16, at 3:22 p.m. trained medication aide (TMA)-A stated the facility typically would only staff, "The bare minimum of what we need," and cares were suffering as a result. TMA-A stated the facility was short staffed, "At least twice a week," and residents had been complaining about their baths and other

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cares not being completed.

During interview on 12/7/16, at 4:03 p.m. NA-D stated the memory care unit was supposed to be staffed with three NA staff and a cart nurse. NA-D stated if they did not have full staffing for the day, then cares suffer and were, "Not that good." Further, NA-D stated residents' range of motion and bathing was not always completed if they were short staffed adding, "Sometimes you can get it, sometimes you can't."

When interviewed on 12/7/16, at 4:47 p.m. licensed practical nurse (LPN)-C stated several residents had voiced concerns about a lack of 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, "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 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 number of NA staff and, "RN/LPN/TMA" staff to have provide care for each shift. The chart

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F 353		F 353		

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identified the following desired staffing levels for a facility census of 70 (as it was during the survey):

- 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 AM shift: 3.5 - 3.6
- Nurse/TMA for PM shift: 3.5 - 3.6
- Nurse/TMA for night shift: 2.0

During an anonymous interview on 12/7/16, a staff member (SM)-A stated the facility was short staffed and baths, "Usually don't get done," as a result. Further, SM-A stated residents had voiced concerns to them about the lack of staff in the facility adding these complaints were heard, "A few times a week."

During an anonymous interview on 12/7/16, SM-B stated the staff end up working short staffed a, "Couple times a week," which results in call lights being answered slower and cares not being provided consistently. SM-B stated the facility used to have pool staff available which was helpful because, "At least [you] had that person there," to help with cares. SM-B stated the staff report these concerns to the nurses, but are just told, "Try to do your best." Further, SM-B stated they were unaware of anything being done by administration to handle or address the lack of staffing in the facility.

During another anonymous interview on 12/8/16, SM-C stated the facility administration had restructured the facility staffing a couple months prior and each unit should have at least two aides working. In addition, two bath aides were being used between the main unit and memory care

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F 353	Continued From page 53 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, however, added she didn't feel there was enough of a concern to justify changing the staffing levels in the facility. Further, the administrator stated the facility was looking at moving to a primary care nursing model and staffing would be adjusted to reflect this.	F 353		

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F 353	Continued From page 54 A facility Nursing Department Staffing policy dated 12/2010, identified an objective, "To provide adequate staffing for the nursing floor," and directed staff to use daily check in sheets to assign scheduled nursing staff to work groups, and attempt to replace a call in if one occurs.	F 353		
F 365 SS=D	483.60(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS (3) Food prepared in a form designed to meet individual needs; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and provide an appropriately textured diet for easy consumption for 1 of 1 residents (R57) who had difficult chewing a regular diet. Findings include: R57's quarterly Minimum Data Set (MDS) dated 10/15/16, identified R57 had moderate cognitive impairment, was independent with eating and had no identified swallowing disorders. During interview on 12/5/16, at 5:07 p.m. R57 stated she had recently lost a tooth and was concerned about it. R57 showed the surveyor her teeth which had visible teeth missing on the upper palate, with several additional teeth broken off at the gum line on her lower palate. R57 stated it was more difficult to chew her food lately without all of her teeth adding she has, "To be careful" with eating now. During observation of the evening meal service	F 365	F365 Food in Form to Meet Individual Needs Talahi Nursing and Rehab Center prepares food in a formed design to meet individual needs. R57 has been evaluated by the dietician for mastication needs and the care plan has been updated to include dietician recommendations. R57 weight and intake are monitored on a regular basis. Dietary Director has reviewed all consistency diets to ensure residents are receiving diets to match their mastication abilities. Concerns identified have been referred to appropriate discipline. ie: ST, Dietician, MD, DDS. Three audits per week for three weeks will be conducted during meal times to identify	1/17/17

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F 365	Continued From page 55 on 12/5/16, at 7:25 p.m. R57 was standing up next to the dining room table. R57 had been served a hamburger and bun, however R57 had only eaten approximately 1/2 of the hamburger and left the other half uneaten on the plate. R57 stated she couldn't keep eating it because it was too hard to chew, "Because of the teeth," as she motioned with her hand to her mouth. R57's Regulatory Visit note dated 11/11/16, identified R57 had been anxious and fixated about, "Dental problems" with teeth having fallen out a month prior. R57's Patient Progress Note dated 10/4/16, was completed by the dentist and identified R57 to have, "Several teeth fractured off at the gumline," adding R57, "States she is having trouble chewing as she is missing so many posterior teeth." Further, the note had a handwriting at the bottom which was dated 10/27/16, and identified the family did not want extensive dental work completed for R57. The note lacked any identified plan to address R57's complaints of difficulty chewing her food. R57's Dietary Assessment dated 10/15/16, identified R57 consumed a regular diet with no texture restrictions and, "No chewing or Swallowing problems" being circled on the assessment. However, the assessment had a separate section labeled, "Notes" which identified she had been seen by the dentist on 10/4/16 with, "Several teeth fractured off [at] gumline, trouble chewing." The assessment lacked any identified plan to address R57's complaints of difficulty chewing her food, or to modify her diet so it was easier for R57 to chew and eat her meal.	F 365	residents whom may be having difficulty masticating. In-services were conducted with nursing staff to ensure they are identifying and endorsing issues like difficulty chewing to management. QAPI committee will review audits for compliance at regularly scheduled meetings and make recommendations for continuance. DON/designee, Dietary Manger, Dietician responsible	

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F 365	Continued From page 56 During interview on 12/6/16, at 2:23 p.m. nursing assistant (NA)-A stated R57 received a regular diet at meals and had only been eating, "Anywhere from 25 to 75 percent" of her meals lately adding she had, "Never seen her finish all her food." Further, NA-A stated she was unaware R57 had made any complaints about having trouble chewing her food. When interviewed on 12/6/16, at 3:29 p.m. speech language pathologist (SLP)-A stated speech had not worked with R57, "In the last few months." SLP-A stated she was unaware R57 was having any troubles chewing her food adding, "This is the first I've heard of it." SLP-A stated the repeated concerns of trouble chewing should have been forwarded to her so they could be addressed as R57 was at a nutritional risk and could potentially just stop eating if she was having trouble chewing, "This is something I would have expected nursing to pass on." When interviewed on 12/7/16, at 11:45 a.m. registered nurse (RN)-B stated she had reviewed R57's weight and intakes and did not feel R57's concern with difficulty chewing was, "Something that had to be addressed," because her intakes were stable. Further, RN-B stated there had been no assessment or plan to address R57's complaints of trouble with chewing her food adding R57, "Appears to be chewing and swallowing just fine." No further information was provided.	F 365		
F 371 SS=F	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or	F 371		1/17/17

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	245438	A. BUILDING ______ B. WING ______	12/08/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 57 considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure left-over foods were discarded timely and cooking equipment was maintained to reduce the risk of food borne illness for 66 of 70 residents who consumed the food prepared in the kitchen. The facility also failed to ensure expired and opened nutritional supplements were not served to 8 of 8 residents (R94, R93, R98, R95, R92, R91, R90, R28) whose nutritional supplements were stored in medication rooms. Findings include:	F 371	F371- Food Procedure/Storage/Sanitary Talahi Nursing and Rehab Center does store food in accordance with professional standards for food service safety. During survey all out dated food was discarded. The identified nonstick frying pans were discarded during the survey. All opened unlabeled undated cans of ensure and jevity were discarded during	

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F 371	Continued From page 58 FACILITY KITCHEN An tour of the facility kitchen was completed on 12/5/16, at 11:58 a.m. with the dietary director (DD). The following items were noted in the facility walk in cooler: - 31-ounce container, of cherry topping dated 11/3/16 -Two-quart container, 1/2 full, of cream style corn dated 11/21/16 -Two hot dogs in a gallon bag dated 11/21/16 -Two quart container 1/8 full of of mixed fruit dated 11/22/16 -Two-quart container, 3/4 full, of fruit cocktail dated 11/22/16 -Two-quart container of peaches, containing approximately 1 1/2 cups, dated 11/24/16 -Two-gallon container, full of sweet potatoes dated 11/24/16 -Two -gallon container of bread stuffing dated 11/24/16 -Three-gallon container of turkey stock dated 11/25/16 During an interview on 12/5/16 at 12:03 p.m., the dietary director (DD) stated the dietary supervisor or chefs were responsible to check for outdated items on a weekly basis. The DD stated that food items can be used up to seven days after initial use, per facility policy. Also observed during the initial tour on 12/5/16 at 12:03 p.m. were two non-stick frying pans on a shelf. The non-stick coating material, over approximately 3/4 of the surface area of both frying pans, was missing and had multiple scratches which exposing the non-stick surface to food items.	F 371	the survey. Staff have been re-educated open containers are not allowed to be stored, unused portions must be discarded immediately. Daily audits are conducted by the cooks to ensure no outdated food is in the kitchen. The Dietary Manager conducts three audits per week for the next two months to ensure there is no outdated food in the kitchen. Medication rooms are audited three times a week for the next two months to ensure there are no opened unused cans of ensure or jevity. Results of the audits will be relayed and discussed at the monthly IDT/QA meeting. DON/designee and Dietary Manager are responsible.	

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F 371	Continued From page 59	F 371		

Continued From page 59

During an interview on 12/5/16 at 12:03 p.m. the DD stated the non-stick fry pans were used to cook up small quantities of food. She would normally dispose the scuffed pans, but was hesitant to do so related to a delay in replacement of equipment.

During a subsequent interview on 12/7/16, at 1:08 p.m., the DD stated the left-over turkey stock and sweet potatoes were from Thanksgiving. They were going to use these items to make soup or gravy stock for future resident meals. The DD stated both items would make approximately ninety-six 1/2 cup servings of soup for the resident in the facility.

During an interview on 12/8/16 at 3:30 p.m. registered dietitian (RD) stated leftover food items should be used in three days or less because of "...the increased risk of food-borne illness."

Although the facility RD identified they had to use leftover food items in three days or less, the items identified in the facility walk in cooler were there 32 to 10 days since being opened.

A facility policy, undated, titled "Food Storage," dated 2009 indicated "Leftover food is used within 7 days or discarded."

MEDICATION ROOMS
During observation on 12/05/16, at 5:10 p.m. of the west medication room there were two opened and undated/unlabeled cans of Ensure (nutritional shake) for R93, R96, R26 and one can of Jevity (nutritional shake) for R94, initialed, but had no opened date.

During observation on 12/05/16, at 6:57 p.m. of

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F 371	Continued From page 60 the North medication storage room an one opened unlabeled/undated can of Ensure for R90. When interviewed on 12/05/16, at 6:57 p.m. registered nurse (RN)-A examined the opened cans of Ensure/Jevity in the North and West medication refrigerators and stated Ensure/Jevity was only good for 24 hours after it is opened. She had "no way of knowing" how long the supplements had been in the refrigerator. Further, RN-A stated all open supplements should have the residents initials and date they were opened to prevent them from being used after their expiration date. During interview on 12/06/16, at 8:49 a.m. the director of nursing stated all supplements should be dated/initialed when opened as they expired within 24 hours after being opened. Review of Abbot manufacturers packet insert, dated 11/2016, for Jevity and Ensure, indicated supplements expire within 48 hours after being opened. A policy for expiration of house supplements was requested, but was not provided during the survey.	F 371		
F 387 SS=D	483.30(c)(1)(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT (c) Frequency of Physician Visits (1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter.	F 387		1/17/17

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F 387	Continued From page 61 (2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure that physician visits were provided at least once every 30 days for the first 90 days after admission for 1 of 5 residents (R31) who were newly admitted to the facility. Findings include: R31's admission minimum data set (MDS), dated 8/26/16, indicated no cognitive impairment. R31's hospital discharge report, dated 8/19/16, indicated she had been admitted to the facility following a hospital stay related to leg pain. R31's diagnosis list, dated 12/7/16, identified an admission diagnoses of cellulitis (skin infection) along with a history of diabetes with nephropathy (kidney damage), heart failure, and chronic obstructive pulmonary disease. A review of physician and physician assistant (PA) notes identified the following: - On 8/31/16, R31 received a visit and was assessed by her from her primary physician. The note indicated that R31 needed monthly visits due to her "Advanced multiple co-morbid conditions with multiple medications" and that "Given long-term placement in skilled nursing facility will need to transfer care." - 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.	F 387	F387- Frequency/Timelines of Physician Visits Talahi Nursing Rehab Center assures residents are seen in a timely manner in accordance with rules and regulations. R31 has been seen by a physician and is followed by the physician on a regular basis. Talahi Nursing and Rehab Center has contracted with new Medical Director to begin 1/1/2017 who is committed to seeing our residents in a timely manner. A calendar has been established to track timely physician services for all new admissions, it is maintained daily by the Health Unit Coordinator and reviewed weekly by the DON. QAPI committee will review audits for compliance at regularly scheduled meetings and make recommendations for continuance. DON/designee, Social Service, Admissions, HUC are responsible.	

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F 387	Continued From page 62 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 would stop seeing a patient when admitted 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 ultimately responsible for overseeing R31's care.	F 387		

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F 387	Continued From page 63 A facility copy of the Combined Federal and States Bill of Rights, dated 11/28/16, directed the facility would seek alternate physician services to "Assure provision of appropriate and adequate care and treatment."	F 387		
F 425 SS=D	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medications were given according to manufactures instructions for 1 of 1 residents (R94). Findings include: MANUFACTURE GUIDELINES: 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 of the mouth.	F 425	F425- Pharmaceutical Services Talahi Nursing Rehab Center does provide pharmaceutical services to meet the needs of each resident. All opened and undated TB PPD vials 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 TB PPD is dated.	1/17/17

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F 425	Continued From page 64 R94's Dismissal Summary from Mayo Clinic dated 12/1/16, indicated R94 had dysphagia (difficulty swallowing) and had a peg (percutaneous endoscopic gastrostomy, which is placed in abdominal wall and stomach to allow nutrition, fluids and/or medications to put directly into the stomach, bypassing the mouth and esophagus) tube placed. Further, R94 was to receive myrbetriq (medication for treatment of overactive bladder) 25 milligrams (mg) sustained release (designed to release medication in body over a extended period of time) by mouth every morning. A speech therapy (ST) Plan Of Care, dated 12/02/16, indicated R94 was unable to swallow on command and had no spontaneous swallow noted. During observation 12/07/16, at 10:40 a.m. listened practical nurse (LPN)- D set up R94's medications. LPN-A crushed all of R94's medications except for THE myrbetriq. LPN-D stated the medication was "sustained released" and could not be crushed, and was ordered to be given by mouth. LPN-D entered R94's room and administered R94's medications, except myrbetriq, via peg tube. LPN-A then stated she would not be able to give R94 myrbetriq because she was uncertain if R94 could swallow the pill. During interview 12/07/16, at 1:00 p.m. LPN-D stated she spoke with R94's physician who discontinued myrbetriq. LPN-D also stated R94 had received the myrbetriq five times since admission, but was uncertain how the staff administered this medication to R94. During interview 12/08/16, at 9:15 a.m. the	F 425	R94 mybetriq was discontinued. DON/designee is responsible to review each MAR on admission to assure proper method of administration is noted. QAPI committee will review audits for compliance at regularly scheduled meetings and make recommendations for continuance. DON/designee is responsible.	

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F 425	Continued From page 65 director of nursing (DON) stated the staff must have been giving the myrbetriq by crushing it, and administering it via the peg tube. The DON stated the nurses should have clarified this order with R94's physician. During a subsequent interview on 12/08/16, at 9:21 a.m. LPN-D stated she had given R94 myrbetriq by crushing it and giving it via R94's peg tube. A facility policy was requested on giving medications according to manufacture specifications and was not received. A Patient Information from the manufacture Astellas Pharma US, Inc. revised August 2016, instructed patients "You should take Mybetriq with water and swallow the tablet whole. Do not crush or chew the tablet".	F 425		
F 431 SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must	F 431		1/17/17

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F 431	Continued From page 66	F 431		

employ or obtain the services of a licensed pharmacist who--

(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

(g) Labeling of Drugs and Biologicals.
Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

(h) Storage of Drugs and Biologicals.
(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and document review, the facility failed to ensure insulin and

F431- Drug Records, Label/Store

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F 431	Continued From page 67 tuberculin solution bottles were dated when open, and expired Novolin, Novolog, Levemir, and Lantus insulin (medication used to treat diabetes) vials were removed from medication carts and not administered to 2 of 11 residents (R2, R31) who used insulin within the facility. Further, facility failed to ensure tuberculin solution was available for resident and staff use and were not expired. This had potential to affect 3 of 9 residents (R93, R98 and R95) who received the expired solution. Findings include: INSULIN R2's quarterly Minimum Data Set (MDS) dated 10/28/16, identified R2 had type two diabetes mellitus (metabolic disease causing increase blood glucose levels and may require insulin). Review of R2's undated physician's orders identified R2 received Novolog (insulin used for diabetes) 90 units subcutaneous (SQ) in the morning and 56 units in the evening. R69's quarterly Minimum Data Set (MDS) dated 10/22/16, identified R69 had type two diabetes mellitus (metabolic disease causing increase blood glucose levels and may require insulin). R31's quarterly Minimum Data Set (MDS) dated 11/19/16, identified R31 had type two diabetes mellitus (metabolic disease causing increase blood glucose levels and may require insulin). Review of R31's undated physician's orders identified R31 received Novolog (insulin used for diabetes) 5 units subcutaneous (SQ) three times a day with meals and 4 units per each carbohydrate four times a day.	F 431	Talahi Nursing and Rehab Center does provide pharmaceutical service to meet the needs of each resident. R2 and R31 insulin were discarded at time of the survey. All insulin is dated when opened. Staff have been re-educated to the procedure of opening and dating insulin. Med carts will be audited two times a week for three weeks to ensure all insulin that is opened is dated. All opened and undated TB PPD vials were 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 TB PPD is dated. R94 Mybetiq was discontinued. DON/designee is responsible to review each MAR on admission to assure proper method of administration in noted. QAPI will review audits for compliance at regularly scheduled meetings and make recommendations for continuance. DON/designee is responsible.	

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F 431	Continued From page 68	F 431		

During observation of the medication cart 12/06/16, at 11:57 a.m. R2's Humulin insulin had a delivery date from the pharmacy on 10/25/16 and R31's Levemir insulin had a delivery date of 10/22/16.

When interviewed on 12/05/16, at 12:25 p.m. nursing assistant (NA)-L stated she did not observe an expiration date on R2's, R31's insulin. Further, NA-L stated there were no other insulin's for these residents on the medication cart which she (NA-L) was aware of.

During interview 12/5/16, 6:43 p.m. registered nurse (RN)-A stated once a resident's insulin was opened it should be labeled with an expiration date as it was only good for 30 days after it has been opened.

A review of a the manufacturers instructions from Elli Lilly instructs to discard Humulin insulin expired 30 days after it is opened. Further, a review of manufacturers instructions from Norvo Nordisk stated Levemir insulin is expired after 42 days after it is opened.

TUBERCULIN:

On 12/05/16, at 05:10 p.m. the West medication storage room was observed with registered nurse (RN)-D. The West medication storage refrigerator contained an opened package of Tuberculin Purified Protein Derivative (TB) (a medication used to test for exposure to Tuberculosis) with an expiration date of 10/10/16, written on the vial. RN-D stated the tuberculin solution was available for residents and facility staff. Further, RN-D stated expired TB solution should not be administered after the expiration date because it

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 69 could cause an "inaccurate result Upon review of documentation titled, "Baseline TB Screening for nursing home and boarding residents" R94 was given an expired TB test (lot number 772984) on 12/1/16, 21 days after it expired. R93 was given expired TB solution (lot number 772984) on 11/22/16, 12 days after it expired and R98 was administered TB test (lot number 772984) on 11/21/16, 11 days after it expired. During observation on 12/05/16, at 05:36 p.m. of the Rosewood medication storage room with assistant director of nursing RN-A. A refrigerator inside the medication room contained an opened package of Tuberculin Purified Protein Derivative with date of when the vial was opened. RN-A stated the tuberculin solution was available for resident use, but was unsure who received the tuberculin solution. Further, RN-A stated the TB solution should have been discarded after 30 days from being opened but they had not way of knowing when the solution was opened since it was not dated. A facility policy on expiration dates for TB solution was requested, but was not provided during the survey. A facility policy titled,"Medication Administration and Storage" dated 3/24/2016, identified, "Insulin is to be dated on the vial or tube when opened." Further, the policy stated to check medication carts for outdated medications weekly.	F 431		
F 441 SS=F	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		1/17/17

REVISED

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	(X3) DATE SURVEY COMPLETED
	245438	A. BUILDING ______ B. WING ______	12/08/2016

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

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F 441	Continued From page 70	F 441		

(a) Infection prevention and control program.

The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);

(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and

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F 441	Continued From page 71 (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on 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:	F 441	F441- Infection Control Talahi Nursing and Rehab Center maintains an infection prevention program. Infection control policies and procedures 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.	

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F 441	Continued From page 72 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: 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 Services reports dated 9/1/16, through 9/30/16, identified different cultures of collected specimens. The reports identified three different residents had urine samples cultured with the same bacteria, however lacked any information on the date of symptom onset, resolution, or if the infection was determined to be community or in-house acquired. 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. OCTOBER 2016:	F 441	Infection control committee meets weekly 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. Nurses have been re-educated on the clean dressing change technique. Random audits will be conducted on staff whom complete dressing changes to ensure proper technique is followed. QAPI committee will review audits for compliance at regularly scheduled meetings and make recommendations for continuance. DON/designee is responsible.	

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F 441	Continued From page 73	F 441		

An Order Listing Report dated 12/5/16, identified six residents had received antibiotics during the month for different diagnosis which included chronic pain syndrome, pneumonia, yeast, and severe sepsis. The report lacked any dates of symptom onset or resolve, organism cultures, room numbers, or if the infection was determined to be community or in-house acquired.

An undated Infection Report Form identified a 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

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F 441	Continued From page 74	F 441		

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 spreading in the facility.

There was no further information provided for any of the identified months of data.

When interviewed on 12/7/16, at 3:36 p.m. the director of nursing (DON) stated the person who had been in charge of the program was no longer employed at the facility and they were in the process of being reassigned to someone else to oversee. Further, the DON stated the infection control program lacked consistent monitoring, trending or analysis of the collected data adding, "We have to come to a better system," and, "Have better tracking of that [infections in the facility]." Further, the DON stated she had been aware the program was lacking these components for the past couple weeks.

During interview on 12/8/16, at 10:32 a.m. the administrator stated staff were, "Always watching" for infections during their regular meetings throughout the week, however do not start any processes for tracking or trending unless patterns of infection are being noted, "I look for the pattern."

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F 441	Continued From page 75	F 441		

A facility Infection Control Program policy dated 2/16/16, identified an objective which included, "Help prevent the development and transmission of disease and infection." The policy identified several elements of the facility program which included, "Surveillance based on systemic data collection," and having, "A system for detection, investigation, and control of outbreaks of infectious disease." Further, the policy identified summaries of the infections were to be compiled and analyzed by the infection control committee, with findings being communicated to determine if changes in practice or procedures were required.

HAND HYGIENE
R39's admission Minimum Data Set (MDS) dated 7/12/16, identified R39 was cognitively intact with a diagnosis of congestive heart failure and an right above the knee amputation. On 10/17/16, R39's significant change in status MDS identified R39 had an unstageable pressure ulcer on R39's left heel and another on his coccyx.
R39's treatment administration record identified a physician order on 11/04/16, for "Dressing change to left heel: Clean open area with normal saline, dry. Cover with Melgisorb dressing. Change daily and on an as needed basis."
During observation on 12/07/16, licensed practical nurse (LPN)-A donned a set of clean gloves. With her clean gloves, LPN-A took off the soiled bandage from R39's left heel and threw it in the trash. Without first removing her soiled gloves, LPN-A-A obtained a new bandage and accidentally dropped it on the floor. She grabbed the bandage off the floor and obtained a pen from her (LPN-A's) pocket to mark a date on the dressing without first removing her soiled gloves. With her same soiled gloves, LPN-A irrigated R39's left heel pressure ulcer. After irrigating

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F 441	Continued From page 76 R39's left heel, R39 placed his clean heel unto the soiled bed linen. With her same soiled gloves, she placed a new clean dressing over R39's left heel and then removed her soiled gloves. LPN-A than proceeded to wash her hands in R39's bathroom. When interviewed on 12/07/16, at 7:33 a.m. licensed practical nurse (LPN)-A stated she contaminated the pressure ulcer on R39's left heel after she (LPN-A) touched the ground and dug in her pocket with her gloved hands. LPN-A stated R39's heel should have not touched the bed after being irrigated because it increased R39's risk for an infection. Further, LPN-A stated it is important to don on a clean set of gloves when working with pressure ulcers because there was a higher risk of "contaminating " the area and an increased risk of infection. During interview on 12/07/16, at 11:18 a.m. the assistant director of nursing (ADON)-A stated wearing dirty gloves could contaminate the area and increased the risk of infection to R39's pressure ulcer on his left heel. When interviewed on 12/07/16, at 11:43 a.m. the director of nursing stated it was "inappropriate " to wear soiled gloves during pressure ulcer treatment as it could increase the risk of infection to the pressure ulcer on R39's left heel. A policy regarding hand hygiene was requested, but not provided during the survey.	F 441		
F 501 SS=D	483.70(h)(1)(2) RESPONSIBILITIES OF MEDICAL DIRECTOR (h) Medical director.	F 501		1/17/17

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F 501	Continued From page 77 (1) The facility must designate a physician to serve as medical director. (2) The medical director is responsible for- (i) Implementation of resident care policies; and (ii) The coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to collaborate with the medical director to address concerns of physician continuity for 1 of 1 residents (R31) who did not receive medical care under a consistent physician. Findings include: R31's admission minimum data set (MDS), dated 8/26/16, indicated no cognitive impairment. R31's hospital discharge report, dated 8/19/16, indicated she had been admitted to the facility following a hospital stay related to leg pain, which also indicated a follow up appointment with her primary physician at the facility in one week. R31's diagnosis list, dated 12/7/16, further identified an admission diagnosis of cellulitis (skin infection) along with a history of diabetes with nephropathy (kidney damage), heart failure, and chronic obstructive pulmonary disease. A review of physician and physician assistant (PA) notes identified the following: On 8/31/16, R31 received a visit and was assessed by her primary medical doctor (MD-B). The note indicated that R31 needed monthly	F 501	F501- Responsibilities of the Medical Director Talahi Nursing and Rehab Center assures resident are seen in a timely manner in accordance with rules and regulations. R31 has been seen by physician and is followed by the physician on a regular basis. Talahi Nursing and Rehab Center has contracted with a new Medical Director to begin 1/1/2017 who is committed to seeing our residents in a timely manner. A calendar has been established to track timely physician services for all new admissions, it si maintained daily by the HUC and reviewed weekly by the DON. QAPI committee will review audits for compliance at regularly scheduled meetings and make recommendations for continuance. DON/designee, Social Services, Admissions, HUC are responsible.	

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F 501	Continued From page 78	F 501		

visits due to her "Advanced multiple comorbid conditions with multiple medications" and that "Given long-term placement in skilled nursing facility will need to transfer care."

On 10/17/16, 47 days after her last physician visit, R31 had an appointment to establish care with a different physician, MD-C outside the facility who assessed R31. The note identified MD-C would be contacting the facility to "Clarify the issue concerning R31's non-eligibility for in-facility care." On 10/24/16, MD-C declined to take R31 as a patient recommending an Internal Medicine Provider, and offered to place referral for the facility.

On 11/3/16, 76 days after her admission, R31 had an appointment with a PA-A. After assessing R31, the PA-A also declined to take R31 as a patient due to her complex medical history and recommended an Internal Medicine Physician.

On 11/18/16, 91 days after she was admitted, R31 had an appointment with a MD-D outside the facility who completed an assessment of R31 and became her primary physician.

A facility Progress Note, dated 9/26/16, indicated the facility had requested the facility's Medical Director (MD)-A to follow R31 starting 9/27/16, because they were unable to find a physician for R31. A Progress Note, dated 10/26/16, indicated the facility Medical Director-A had declined to follow R31 as a patient.

R31's medical record lacked any indication the Medical Director-A had completed an assessment of R31 in September, when R31 was not seen within 30 days of her last physician assessment.

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There was also no indication the Medical Director-A had been contacted to assist R31 to establish care with a primary physician.

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. R31 stated she hadn't been seen by the Medical Director, but had been told he couldn't follow her due to age and insurance. R31 stated since the facility's Medical Director wouldn't see her, she "was hanging again" and was "Just hoping and praying things got better."

During interview on 12/7/16, at 5:29 p.m. MD-A stated he wasn't able to take R31 as a patient due to her younger age. He further stated he hadn't seen R31 in person in September, just reviewed her chart and thought she was already referred to another physician. The MD-A was unaware R31 had not been assessed by a physician in September or that she was denied care twice. The MD-A would have expected the facility to contact him when R31 was denied care stating he was ultimately responsible for her care.

During interview on 12/8/16, at 11:03 a.m. director of nursing (DON) stated MD-A should have been involved in finding care for R31 since he had refused to follow her as her primary physician.

The facility's Medical Director Agreement, reviewed 1/29/16, identified the responsibilities to include the "Overall coordination of medical care in the facility to ensure the adequacy and appropriateness of the medical services provided to residents."

REVISED

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND 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**	STREET ADDRESS, CITY, STATE, ZIP CODE **1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 156	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES

(d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care.

§483.10(g) Information and Communication.
(1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility.

(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including:

(i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes -

(A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section;

(B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act.

(C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and

(D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.

(ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.)
[§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)]

(iii) Information regarding Medicare and Medicaid eligibility and coverage;
[§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)]

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

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES

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Continued From Page 1

(iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program;
[§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)]

(v) Contact information for the Medicaid Fraud Control Unit; and
[§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)]

(vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.

(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives:

(i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and

(ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community.

(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 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 resident with the State-developed notice of Medicaid rights and obligations, if any.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND 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**	STREET ADDRESS, CITY, STATE, ZIP CODE **1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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(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, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-

(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 resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section.

(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.

(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.

(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.

(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.

(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.

v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.
This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to provide the appropriate liability notice to 2 of 6 residents (R64 and R91) reviewed who were discharged from Medicare services.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	245438	A. BUILDING: ______ B. WING ______	12/8/2016

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

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Findings include:

R64's admission Minimum Data Set (MDS), dated 10/28/16, indicated R64 received physical and occupation therapy while admitted in the facility.

R64's was provided and signed a Notice of Medicare Non-Coverage CMS 10095 (which explains a resident's right to an immediate appeal through the QIO or Quality Improvement Organization) on 11/4/16, identifying R64's Medicare services were ending on 11/7/16. R64 was discharged from the facility on 11/8/16. R64's received notice form CMS 10095, which identified Straits Health as the QIO. R64 should have received the form CMS 10123, and not the CMS 10095, which was the incorrect 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.

R91 received and signed liability notice form CMS 10095 on 11/22/16, regarding Medicare services ending on 11/24/16. Since R91 remained in the facility, he also received the a SNF determination on continued stay (which explains a resident's financial obligations when Medicare services end). R91 should have received the form CMS 10123, and not the CMS 10095, which was the incorrect 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 CMS 10095 form, expired 10/31/2013, over three years ago, and had been replaced with the CMS 10123.

A copy of the facility's policy was requested, but not provided.

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00614	A. BUILDING: ______ B. WING ______	C **12/08/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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

Electronically Signed — 01/04/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 12/05/16 through 12/08/16, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. In addition, an investigation of complaint H5438047 was completed and substantiated with a deficiency cited at F353 during the survey. An investigation of complaint H5438046 was completed, and found to be unsubstantiated.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the plan of care was implemented for 4 of 5 residents (R41, R49, R94 and R87) reviewed who were	2 565	Completed	1/17/17

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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TALAHI NURSING AND REHAB CENTER	**1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304**

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2 565	Continued From page 2	2 565		

dependent on staff for activities of daily living (ADLs).

Findings include:

BATHING
R41's quarterly Minimum Data Set (MDS) dated 11/21/16, identified R41 was moderately cognitively impaired and required total assistance from facility staff for activities of daily living (ADL)'s. In addition, R41 had no rejection of ADL's during the MDS assessment period.

R41's plan of care, dated 10/06/16, noted R41 had an identified problem for ADL self-care deficit related to her (R41's) dementia. Further, the care plan identified R41 required extensive assistance of 1 with ADL's and was to receive a tub bath once a week as requested by R41. In addition, the care plan noted R41 was to be provided a sponge bath, when a full bath could not be tolerated.

During an interview with R41 on 12/05/16, at 12:41 p.m. R41 stated she had not received weekly scheduled bath on a "regular basis " and was concerned because she required assistance from facility staff with her ADL's.

R41's Body Audit Form identified R41 had 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 indication that R41 had rejected ADL's with bathing 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

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2 565	Continued From page 3 unaware of R41 refusing a bath in the past, but was a "tough one" to bathe. 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 according to her care plan. Further RN-D stated R41's baths,"were not happening "according to the body audit forms. During interview on 12/07/16, at 11:26 a.m. with director of nursing (DON) stated she was aware residents in the facility were not receiving their baths as directed by the care plan. INCONTINENCE R94's Admission Record undated indicated she had dementia and neurological disease. A facility Continence Evaluation form dated 12/06/16, indicated she was incontinent of bladder, onset was unknown, unable to sit on the toileted and was not motivated to toilet. R94's Individual Resident Care Plan (temporary care plan) dated 12/1/16, indicated she was incontinent of bowel and bladder and toilet on rounds (every two hours). The care plan indicated R94 was high risk for falls, was unable to reposition herself. R94's nursing assistant care sheet, undated, instructed staff to toilet the resident every two hours. During continuous observation on 12/07/16, from 6:00 a.m. to 8:34 a.m. (2 hours and 34 minutes) R94 was lying in her bed on her right side with her nightgown on. There was no staff for R94 observed during this time. A 7:52 a.m. nursing	2 565		

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2 565	Continued From page 4	2 565		

Continued From page 4

assistant (NA)-E looked into R94's room and walked by. At 8:13 a.m. NA-E entered R94's room stated he was checking on R94, but did not provide R94 with any cares. At 8:34 a.m. NA-E re-entered the room and removed R94's pad which was moderately soaked with urine, and had a small bowel movement. R94's entire peri- area was red and excoriated (damage or remove part of the surface of the skin). NA-E stated her bottom was very red, and applied peri cream to the area. NA-E stated he started at 6:00 a.m. and this was the first time during his shift he had provided cares to R94. NA-E said he did not know when R94 was last changed.

During interview 12/07/16, at 1:10 p.m. registered nurse (RN)-C stated R94 was incontinent of urine and should be toileted every two hours according to her care plan.

FALL INTERVENTIONS
R87's admission Minimum Data Set (MDS), dated 10/4/16, identified R87 was mildly, cognitively impaired, used a wheelchair for locomotion, and was at risk for falls and dependent upon staff for activities of daily living.

R87's care plan, dated 11/8/16 identified R87 at high risk for falls and included interventions for "Dycem non-slip material to remain in wheelchair at all times while resident is up in chair." R87's care plan did not direct staff to fasten the wedge cushion to the wheelchair.

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 the evening meal at 4:48 p.m., R87 was again observed seated in his wheelchair, and no Dye was present in the wheelchair. During

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2 565	Continued From page 5 observation on 12/8/16, at 9:09 a.m. R87 was seated in his wheelchair during breakfast, and no Dycem was observed in R87's wheelchair. During interview on 12/8/16, at 9:16 a.m. nursing assistant (NA)-F stated R87 did not have any Dycem in his wheelchair. NA-F stated she was unaware of dycem being a fall intervention, or was needed in R87's wheel chair. During interview on 12/8/16 at 11:13 a.m., the director of nursing (DON) stated fall interventions were communicated to staff daily at morning meetings. The DON further stated staff were expected to remember the interventions, and be implementing them. A policy regarding implementation of resident care plans was requested, but not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could inservice staff about implementing the care plan and then audit cares to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the	2 570		1/17/17

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2 570	Continued From page 6 participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to update the resident plan of care for falls with new interventions after a reassessment was completed for 1 of 2 residents (R92) reviewed for falls. Findings include: R92's diagnoses, as identified on the face sheet dated 12/8/16, included chronic respiratory failure, anxiety disorder and weakness. R92's admission Minimum Data Set (MDS) dated 11/22/16 indicated moderately impaired cognition. The care area assessment (CAA) for falls dated 11/22/16 identified R92 was at risk for falls due to shortness of breath with activity, unsteady gait and balance. The CAA also indicated R92 was working with therapy for strengthening and endurance, was making progress, and staff were to assist with mobility and transfers. During observation on 12/06/16 at 2:22 p.m., R92 was seated in her wheel chair just outside her room door. R92 wore shoes and socks, had oxygen tubing to the right of the wheel chair, with a nasal cannula in place. Clipped to her shirt was a cord, which lead directly to a TABS (a personal, movement-detecting safety) alarm, fastened to the back of the wheel chair. Review of an Investigation Report dated 11/22/16	2 570	Completed	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 570	Continued From page 7	2 570		

indicated R92 had an unwitnessed fall in her room on 11/20/16. The interdisciplinary team added an intervention to place a TABS (a personal, movement-detecting safety) alarm for R92 when in wheel chair or in bed.

The care plan, revised 11/21/16, identified R92 was at high risk for falls, and directed staff to: anticipate and meet resident's needs; be sure the call light is within reach and encourage to use; encourage resident to participate in activities that promote exercise for strengthening; ensure resident is wearing appropriate footwear; follow fall protocol; and PT (physical therapy) evaluate and treat. R92's care plan lacked the TABS alarm intervention.

Review of the nursing aide care sheets, undated, identified R92 required stand by assist, was a moderate fall risk, was to bet toiled every 2 hours, and had a regular diet. The sheet did not include R92's fall intervention to use the TABS alarm.

During an interview on 12/8/16 at 10:02 a.m., nursing assistant (NA)-I stated she always carried and used her nursing sheet. After reviewing the sheet, NA-I said there was nothing about R92's alarm, "but I know [R92] is supposed to have the alarm on." NA-I stated she learns of changes to residents care plans at the change of shift meetings, but it would be important to know the care plan, especially 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 care plan in the resident's chart should have been updated, as well as the aide cares sheets. The DON stated the unit managers were responsible, and it was a matter of getting that task "completed and updated."

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2 570	Continued From page 8 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 provide 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.	2 570		
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:	2 800		1/17/17

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2 800	Continued From page 9 Based on observation, interview and document review, the facility failed to provide sufficient nursing staff to meet assessed resident needs for 4 of 5 residents (R41, R49, R94 and R87) reviewed for activities of daily living, 1 of 3 residents (R94) reviewed for pressure ulcers, and for 4 of 4 residents (R3, R50, R80, R20) and 10 of 10 staff members (NA-A, NA-C, NA-B, TMA-A, NA-D, LPN-C, SM-A, SM-B, SM-B, RN-A) who voiced concerns with the lack of sufficient nursing staff in the facility. Findings include: ASSESSED RESIDENT NEEDS NOT BEING MET: See F282: The facility failed to ensure the plan of care was implemented for 4 of 5 residents (R41, R49, R94 and R87) reviewed who were dependent on staff for activities of daily living (ADLs). See F312: The facility failed to provide baths and timely toileting assistance for 2 of 3 residents (R41, R94) reviewed that were dependent upon staff for activities of daily living (ADLs). See F314: The facility failed to provide timely assistance for toileting and repositioning to reduce the risk of pressure ulcer development for 1 of 3 residents (R94) identified at risk of pressure ulcers. RESIDENT CONCERNS WITH LACK OF STAFFING: R3's quarterly Minimum Data Set (MDS) dated 8/23/16, identified R3 had intact cognition and	2 800	Completed	

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

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required extensive assistance with ADLs.

During interview on 12/5/16, at 3:12 p.m. R3 stated the facility lacked sufficient nursing staff to meet her needs timely. R3 stated the nursing staff were getting, "Sloppy on cares," because they had to rush through them due to not having enough staff. R3 stated she was incontinent of urine that same day because she didn't get help with toileting quickly enough adding it made her feel, "Upset and furious."

R3's Device Activity Report dated 11/24/16 to 12/8/16, identified the following call light response times:
- On 11/25/16, at 11:27 a.m. the call light was on for 22 minutes and 17 seconds;
- On 11/25/16, at 1:46 a.m. the call light was on for 43 minutes and 35 seconds;
- On 11/27/16, at 1:00 p.m. the call light was on for 18 minutes and 15 seconds;
- On 11/28/16, at 7:58 a.m. the call light was on for 16 minutes and 25 seconds;
- On 11/30/16, at 11:39 a.m. the call light was on for 15 minutes and 14 seconds;
- On 11/30/16, at 6:52 p.m. the call light was on for 21 minutes and 8 seconds;
- On 12/2/16, at 8:37 a.m. the call light was on for 59 minutes and 20 seconds and;
- On 12/2/16, at 12:35 a.m. the bathroom call light was on for 47 minutes and 45 seconds.

R50's quarterly MDS dated 9/20/16, identified R50 had intact cognition and required extensive assistance with his activities of daily living (ADLs).

During interview on 12/5/16, at 2:10 p.m. R50 stated the facility needed more staff to completed resident care. R50 stated he needs help to use

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the bathroom and, at times, has come, "Pretty close" to having incontinence because there is not enough staff to assist him promptly.

R50's Device Activity Report dated 11/24/16 to 12/8/16, identified the following call light response times:
- On 11/30/16, at 2:01 a.m. the call light was on for 23 minutes and 32 seconds;
- On 11/30/16, at 11:42 a.m. the call light was on for 19 minutes and 28 seconds;
- On 12/7/16, at 3:03 a.m. the call light was on for 16 minutes and 32 seconds and;
- On 12/7/16, at 7:13 a.m. the call light was on for 20 minutes and 41 seconds.

R80's annual MDS dated 11/15/16, identified R80 had intact cognition and required extensive assistance with ADLs.

During interview on 12/5/16, at 2:30 p.m. R80 stated the facility was not adequately staffed. R80 stated she had waited up to 30 minutes for assistance before and at times just has to, "Hang on," to her bladder so she doesn't have incontinence.

R80's Device Activity Report dated 11/24/16 to 12/8/16, identified the following call light response times:
- On 11/30/16, at 6:52 p.m. the call light was on for 22 minutes and 7 seconds;
- On 12/7/16, at 7:10 a.m. the call light was on for 18 minutes and 41 seconds and;
- On 12/7/16, at 11:36 a.m. the call light was on for 16 minutes and 54 seconds.

R20's quarterly Minimum Data Set (MDS) dated

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10/6/16, identified R20 had moderate cognitive impairment.

During interview on 12/5/16, at 6:11 p.m. R20 stated the facility did not have enough staff to provide timely assistance with his needs. R20 stated he often has to wait up to 15 minutes for help, even after already asking for assistance. Further, R20 stated he had fallen in the hallway before and it took several minutes before staff responded to help him.

STAFF CONCERNS WITH LACK OF STAFFING:

During interview on 12/6/16, at 2:06 p.m. nursing assistant (NA)-A stated the facility is typically short staffed, "A couple times a week," and residents become upset their cares are not completed in a timely manner adding, "They [residents] can sense it." NA-A stated the resident baths are not always completed if they are short staffed and staff run around the facility, "Like chickens with their heads cut off," trying to get cares completed.

When interviewed on 12/6/16, at 2:28 p.m. NA-C stated the nursing staff was, "Really short," some days and being full staffed with four aides on the main unit of the facility was not consistently happening anymore adding, "We're lucky if we get four aides." NA-C stated it was difficult to complete all of the assigned cares for residents, like bathing, because of the lack of staffing. NA-C stated the residents, "Get really upset," when their baths and cares aren't completed. Further, NA-C stated several staff had reported the concerns with lack of sufficient staff to the nurse managers and administration of the facility, however, staff are just told, "We're working on it."

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During interview on 12/6/16, at 2:45 p.m. NA-B stated the memory care unit is typically staff with just two NA staff and a cart nurse. NA-B stated the memory care unit used to be staffed with three NA staff though, however, it was changed because administration felt people were just, "Standing around down here." NA-B stated two NA staff was not enough to care for the residents adequately or safely, "You need to have three aides because of the behaviors we have." NA-B stated resident care was suffering as a result of the lack of sufficient staffing adding, "They're [resident] not getting bathed," consistently. Further, NA-B stated these concerns regarding the lack of staff had been, "Voiced strongly," to managers and administration.

When interviewed on 12/6/16, at 3:22 p.m. trained medication aide (TMA)-A stated the facility typically would only staff, "The bare minimum of what we need," and cares were suffering as a result. TMA-A stated the facility was short staffed, "At least twice a week," and residents had been complaining about their baths and other cares not being completed.

During interview on 12/7/16, at 4:03 p.m. NA-D stated the memory care unit was supposed to be staffed with three NA staff and a cart nurse. NA-D stated if they did not have full staffing for the day, then cares suffer and were, "Not that good." Further, NA-D stated residents' range of motion and bathing was not always completed if they were short staffed adding, "Sometimes you can get it, sometimes you can't."

When interviewed on 12/7/16, at 4:47 p.m. licensed practical nurse (LPN)-C stated several residents had voiced concerns about a lack of

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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, "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 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 number of NA staff and, "RN/LPN/TMA" staff to have provide care for each shift. The chart identified the following desired staffing levels for a facility census of 70 (as it was during the survey):

- 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 AM shift: 3.5 - 3.6
- Nurse/TMA for PM shift: 3.5 - 3.6
- Nurse/TMA for night shift: 2.0

During an anonymous interview on 12/7/16, a staff member (SM)-A stated the facility was short staffed and baths, "Usually don't get done," as a result. Further, SM-A stated residents had voiced concerns to them about the lack of staff in the

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facility adding these complaints were heard, "A few times a week."

During an anonymous interview on 12/7/16, SM-B stated the staff end up working short staffed a, "Couple times a week," which results in call lights being answered slower and cares not being provided consistently. SM-B stated the facility used to have pool staff available which was helpful because, "At least [you] had that person there," to help with cares. SM-B stated the staff report these concerns to the nurses, but are just told, "Try to do your best." Further, SM-B stated they were unaware of anything being done by administration to handle or address the lack of staffing in the facility.

During another anonymous interview on 12/8/16, SM-C stated the facility administration had restructured the facility staffing a couple months prior and each unit should have at least two aides working. In addition, two bath aides were being 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

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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, however, added she didn't feel there was enough of a concern to justify changing the staffing levels in the facility. Further, the administrator stated the facility was looking at moving to a primary care nursing model and staffing would be adjusted to reflect this.

A facility Nursing Department Staffing policy dated 12/2010, identified an objective, "To provide adequate staffing for the nursing floor," and directed staff to use daily check in sheets to assign scheduled nursing staff to work groups, and attempt to replace a call in if one occurs.

SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could review current and ongoing staffing patterns to evaluate if addition or relocation of staff is needed to ensure all resident cares needs are met.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

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2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate supervision, and interventions were implemented to prevent accident hazards for 4 of 5 residents (R87, R49, R75, R37) reviewed for accidents. In addition, the facility failed to ensure bed rails were properly fastened and secured to the bed frame to promote safety for 1 of 20 residents (R3) who had loose bed rails. Findings include: FALLS R87's admission Minimum Data Set (MDS), dated 10/4/16, identified R87 was cognitively impaired, used a wheelchair for locomotion, and was at risk for falls. R87's admission Care Area Assessment (CAA), dated 10/10/16, identified R87 was at risk for falls	2 830	Completed	1/17/17

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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 the evening meal at 4:48 p.m., R87 was again observed seated in his wheelchair, and no dycem was present in the wheelchair. During observation on 12/8/16, at 9:09 a.m. R87 was seated in his wheelchair during breakfast, and no dycem was observed in R87's wheelchair.

During interview 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.,

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registered nurse (RN)-C stated R87 no longer needed the dycem in his wheelchair once R87 received the new wheelchair cushion, which provided a non slip surface. RN-C stated the care plan had not been revised to discontinue the dycem.

During interview on 12/8/16, at 10:02 a.m. occupational therapist (OT)-A stated R87 needed the dycem in his wheelchair, and his wheelchair cushion did not provide an appropriate non slip surface.

During interview on 12/8/16 at 11:13 a.m., the director of nursing (DON) stated fall interventions were communicated to staff daily at morning meetings. The DON further stated staff were expected to remember the interventions, and be implementing them.

A facility policy titled "Fall Prevention," dated 9/1/16, directed all new admissions to the facility would be assessed for fall risk. The fall interventions on the care plan and assessment were to be implemented.

COFFEE BURN
R49's quarterly MDS dated 10/15/16, indicated R49 was severely cognitively impaired, and needed supervision and set up with eating.

A Progress Note dated 7/27/16, at 11:34 a.m. indicated R49 had picked up the coffee cup, was moving cup to her mouth spilled the hot coffee on left arm and lap. Reddened area appeared on left arm approximately "5' (inches) by 2", lap was reddened area on left leg 8" by 4", right leg 7" by 3".

A Risk Management report dated 7/27/16,

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indicated "Client was sitting at table in dinning room for breakfast. Client was given beverages prior to getting meal. While client was waiting for breakfast client grabbed the cup, moved it toward her mouth and accidentally spilled her coffee on her left arm and lap." Writer placed intervention in place for staff to fill coffee/hot liquid containers half full and add ice cubes to cool to room temp prior to serving, signage placed in front of the coffee carafes in east kitchen to remind staff of intervention.

R49's care plan dated 08/10/16, indicated "This resident required a mechanical soft diet and cueing by staff to eat. Cut up food as needed, coffee fill cup half-full and cool with ice prior to placing at the table, coffee should be luke-warm."

During observation 12/07/2016, at 12:34 p.m., nursing assistant (NA)-G provided R49 with her lunch tray along with a cup of coffee 3/4 full. There was no ice in the coffee, and steam was observed coming from the top of the coffee cup.

During interview on 12/07/16, at 12:40 p.m. NA-G stated she was not aware of any interventions they provide to keep R49's coffee luke warm.

During interview on 12/07/16, at 2:22 p.m., registered nurse (RN)-B stated R49's coffee should be luke warm by adding water. RN-B then stated R49's care plan indicated ice should be placed in her cup to keep it luke warm, not water. RN-B thought that intervention for R49 had changed.

RESIDENT TO RESIDENT ALTERCATION
R75's quarterly Minimum Data Set (MDS) dated 11/5/16, indicated she was severely cognitively

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impaired and depressed.

R75's care plan dated 09/29/16, indicated she had a behavior of repeatedly asking for certain staff, related to dementia with behavior disturbance. The care plan directed staff to assist R75 to develop more appropriate methods of coping and interacting, and to encourage R75 to express feelings appropriately.

R37's quarterly MDS dated 11/1/16, indicated she was severely, cognitively impaired and had diagnoses which included dementia.

A progress note dated 10/12/16 at 3:58 p.m. indicated R75 was observed to hover over another resident (R37). The note indicated staff instructed R75 to stay away from the other resident's personal space, because R37 was agitated. R75 walked over and gave R37 a left sided upper body hug. R37 swung their right fist and hit R75 in the head. There were no apparent injuries. R75 was again advised to go to her room if she couldn't keep to herself. R75 did go to her room and no further behaviors were identified.

An Incident Report dated 10/13/16, indicated that on 10/12/16, in the afternoon staff had noted R75 standing near R37, showing concern for her. Staff offered R75 reassurance and asked her to give R37 some personal space as R37 displayed some agitation towards others at this time. R37 was in Broda chair (tilting and reclining wheelchair) and R75 was ambulating using her walker. She preceded to walk up to R37 and gave her a left sided hug. R37 then proceeded to make a fist with her right hand and strike R75.

Although staff offered reassurance to R75 before

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the altercation with R37. There was no change with interventions implemented for either resident, after R37 struck R75, to help reduce the risk of resident to resident altercations and keep both residents safe.

LOOSE SIDE RAILS
R3's quarterly Minimum Data Set (MDS) dated 8/11/16 identified R3 was cognitively intact and required extensive assistance with activities of daily living (ADL's). R3 had a diagnosis of severe morbid obesity and generalized muscle weakness.

During observation on 12/05/16, at 3:10 p.m. R3's bed was fitted with bilateral, quarter side rails, approximately 24" (inches) in length and 8" in height. The rails were fastened to bed frame, with a screw. When grasped, each rail could be moved back and forth approximately 2" from the bed frame.

During interview on 12/05/16, at 3:19 p.m. with registered nurse (RN)-E stated (R3's) side rails felt "very loose" and was a safety risk for R3. Further, RN-E stated R3 frequently used the side rails to assist her in sitting up in bed.

When interviewed on 12/05/16, at 3:22 p.m. R3 stated the side rails had always been "very loose" and were difficult to use when they were that loose.

During interview on 12/05/16, at 6:53 p.m. the registered nurse (RN)-A stated R3's side rails felt "wobbly" which placed the resident at risk for falls and may become an entrapment risk if the side rails became any looser.

On 12/08/16, at 1:03 p.m. MS stated the usual

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 23 facility practice was for facility staff to notify maintenance with concerns with paper slips. Further, MS stated there was no system in place for side rail maintenance. Review of policy titled, "Side Rails" dated 6/11/16 identified staff members are to assess the side rail is safe, provide education to residents and are utilized within manufacture's instructions. SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could review and reeducate all staff on the policies and procedures to ensure that all residents at risk for accidents were reassessed, interventions implemented and properly supervisor to prevent accident hazards. The director of nursing or her designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 835	MN Rule 4658.0520 Subp. 2 A Adequate and Proper Nursing Care; Criteria Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: Evidence of adequate care and kind and considerate treatment at all times. Privacy must be respected and safeguarded. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide baths and	2 835	Completed	1/17/17

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2 835	Continued From page 24	2 835		

timely toileting assistance for 2 of 3 residents (R41, R94) reviewed that were dependent upon staff for activities of daily living (ADLs).

Findings include:

R41's quarterly Minimum Data Set (MDS) dated 11/21/16, identified R41 was moderately cognitively impaired and required total assistance for ADL's. In addition, R41 had no rejection of ADL's during the MDS assessment period.

R41's plan of care dated 10/06/16, noted R41 had an identified problem for ADL self-care deficit related to her (R41's) dementia. Further, the care plan identified R41 required an extensive assistance of one with ADL's and was to receive a tub bath once a week as requested by R41. In addition, the care plan noted R41 was to be provided a sponge bath when a full bath could not be tolerated.

During an interview with R41 on 12/05/16, at 12:41 p.m. R41 stated she had not received weekly scheduled baths on a "regular basis "and was concerned because she required assistance from facility staff for her ADL's.

R41's Body Audit Form identified R41 had 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

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2 835	Continued From page 25	2 835		

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 bowel and bladder and was toileted on rounds. An untitled and undated nursing assistant care sheet, identified R94 was to be toileted every two hours.

A Continence Evaluation assessment dated 12/06/16, indicated R94 was incontinent of bladder and wore a brief. The assessment further indicted it was unknown if R94 had an urge to void and did not use the toilet.

During continuous observation on 12/07/16, from 6:00 a.m. to 8:34 a.m. (2 hours and 34 minutes) R94 was lying in her bed on her right side with

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2 835	Continued From page 26 her nightgown on. There was no staff for R94 observed during this time. A 7:52 a.m. nursing assistant (NA)-E looked into R94's room and walked by. At 8:13 a.m. NA-E entered R94's room stated he was checking on R94, but did not provide R94 any cares. At 8:34 a.m. NA-E re-entered the room and removed R94's pad which was moderately soaked with urine, and had a small bowel movement. R94's entire peri- area was red and excoriated (damage or remove part of the surface of the skin). NA-E stated her bottom was very red, and applied peri cream to the area. NA-E stated he started at 6:00 a.m. and this was the first time during his shift he had provided cares to R94. NA-E said he did not know when R94 was last changed. During interview 12/07/16, at 1:10 p.m. RN-C stated R94 was incontinent of urine. RN-C reported (R94) was dependent upon staff and at risk for skin breakdown, and should be checked and changed every two hours. SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service staff responsible for meeting bathing and toileting for residents. The facility could develop a monitoring system to ensure ongoing compliance and report the findings to the Qualify Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 835		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers	2 900		1/17/17

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2 900	Continued From page 27 Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide timely assistance for toileting and repositioning to reduce the risk of pressure ulcer development for 1 of 3 residents (R94) identified at risk of pressure ulcers. Findings include: R94's undated Admission Record indicated R94 was admitted on 12/01/16, which included diagnoses of dementia and multiple sclerosis (A disease in which the immune system eats away at the protective covering of nerves). R94's admission Minimum Data Set (MDS) was not completed. A Braden Skin assessment (scale for predicting pressure ulcer risk) dated 12/01/16, indicated R94 had occasionally moist skin, was bed fast,	2 900	Completed	

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2 900	Continued From page 28	2 900		

had very limited mobility, with a potential problem of friction and shear. The assessment had a score of 14 which indicated R94 was at moderate risk for developing a pressure ulcer.

R94's Individual Resident Care Plan (temporary care plan) dated 12/1/16, indicated R94 was incontinent of bowel and bladder and was to be toileted on rounds. R94's care plan did not indicate she was at risk for pressure ulcers.

During continuous observation on 12/07/16, from 6:00 a.m. to 8:34 a.m. (2 hours and 34 minutes) R94 was lying in her bed on her right side with her nightgown on. There was no staff for R94 observed during this time. At 7:52 a.m. nursing assistant (NA)-E looked into R94's room and walked by. At 8:13 a.m. NA-E entered R94's room and said he was checking on R94, but did not provide R94 any cares. At 8:34 a.m. NA-E re-entered the room and removed R94's pad which was moderately soaked with urine, and had a small bowel movement. R94's entire peri- area was red and excoriated (damage or remove part of the surface of the skin). NA-E stated her bottom was very red, and applied peri cream to the area. NA-E stated he started at 6:00 a.m. and this was the first time during his shift he had provided cares to R94. NA-E said he did not know when R94 was last changed.

During interview 12/07/16, at 1:10 p.m. registered nurse (RN)-C stated R94 was incontinent of urine, and at risk for skin breakdown. She should be checked/changed every two hours and repositioned during this time.

A facility policy "Prevention and Treatment of Skin Breakdown." reviewed 3/2016, directed staff to "Properly identify and assess residents who's

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2 900	Continued From page 29 clinical conditions increase the risk for impaired skin integrity, and pressure ulcers, to implement preventative measures, and to provide appropriate treatment modalities for wounds according standards of care." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could inservice staff regarding implementation of a care plan to ensure appropriate treatment of pressure ulcers, and then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by:	2 910		1/17/17

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2 910	Continued From page 30 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 Findings include: R38's admission Minimum Data Set (MDS) dated 08/04/16, indicated R38 was always continent of urine. The quarterly MDS dated 10/31/16, indicated R38 was frequently incontinent of urine (7 or more episodes of incontinence but at least one episode of continence). The care area assessment (CAA) dated 8/10/16, identified R38 was on a diuretic (reduces fluid), and needed assistance with toileting. Further, the CAA identified R38 did not always ask for assistance due to cognitive impairment, and staff were to toilet R38 every two hours. R38's care plan dated 08/09/16, indicated he required extensive assistance of one for toileting. A Bladder 7 Day Documentation from 7/28/16 thru 8/4/16, indicated R38 was never incontinent of urine. A subsequent bladder assessment from 10/26/16 thru 11/1/16, indicated R38 was incontinent of urine nine times, which was a change in status from his previous assessment in August 2016. The quarterly bladder assessment dated 11/1/16 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.	2 910	Completed	

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2 910	Continued From page 31	2 910		

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 1:45 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. 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 possible.

SUGGESTED METHOD OF CORRECTION:
The director of nursing or designee, could review all residents who needed assistnace with toileting, to assure they are receiving the necessary treatment/services to prevent potential decline in toileting. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented.

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2 910	Continued From page 32 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		
21235	MN Rule 4658.0700 Subp. 2 C Medical Director;Develop standard of Practice Subp. 2. Duties. The medical director, in conjunction with the administrator and the director of nursing services, must be responsible for: C. the development of standards of practice for medical care to provide guidance to attending physicians; This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to collaborate with the medical director to address concerns of physician continuity for 1 of 1 residents (R31) who did not receive medical care under a consistent physician. Findings include: R31's admission minimum data set (MDS), dated 8/26/16, indicated no cognitive impairment. R31's hospital discharge report, dated 8/19/16, indicated she had been admitted to the facility following a hospital stay related to leg pain, which also indicated a follow up appointment with her primary physician at the facility in one week. R31's diagnosis list, dated 12/7/16, further identified an admission diagnosis of cellulitis (skin infection) along with a history of diabetes with nephropathy (kidney damage), heart failure, and	21235	Completed	1/17/17

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21235	Continued From page 33 chronic obstructive pulmonary disease. A review of physician and physician assistant (PA) notes identified the following: On 8/31/16, R31 received a visit and was assessed by her primary medical doctor (MD-B). The note indicated that R31 needed monthly visits due to her "Advanced multiple comorbid conditions with multiple medications" and that "Given long-term placement in skilled nursing facility will need to transfer care." On 10/17/16, 47 days after her last physician visit, R31 had an appointment to establish care with a different physician, MD-C outside the facility who assessed R31. The note identified MD-C would be contacting the facility to "Clarify the issue concerning R31's non-eligibility for in-facility care." On 10/24/16, MD-C declined to take R31 as a patient recommending an Internal Medicine Provider, and offered to place referral for the facility. On 11/3/16, 76 days after her admission, R31 had an appointment with a PA-A. After assessing R31, the PA-A also declined to take R31 as a patient due to her complex medical history and recommended an Internal Medicine Physician. On 11/18/16, 91 days after she was admitted, R31 had an appointment with a MD-D outside the facility who completed an assessment of R31 and became her primary physician. A facility Progress Note, dated 9/26/16, indicated the facility had requested the facility's Medical Director (MD)-A to follow R31 starting 9/27/16, because they were unable to find a physician for R31. A Progress Note, dated 10/26/16, indicated	21235		

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the facility Medical Director-A had declined to follow R31 as a patient.

R31's medical record lacked any indication the Medical Director-A had completed an assessment of R31 in September, when R31 was not seen within 30 days of her last physician assessment. There was also no indication the Medical Director-A had been contacted to assist R31 to establish care with a primary physician.

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. R31 stated she hadn't been seen by the Medical Director, but had been told he couldn't follow her due to age and insurance. R31 stated since the facility's Medical Director wouldn't see her, she "was hanging again" and was "Just hoping and praying things got better."

During interview on 12/7/16, at 5:29 p.m. MD-A stated he wasn't able to take R31 as a patient due to her younger age. He further stated he hadn't seen R31 in person in September, just reviewed her chart and thought she was already referred to another physician. The MD-A was unaware R31 had not been assessed by a physician in September or that she was denied care twice. The MD-A would have expected the facility to contact him when R31 was denied care stating he was ultimately responsible for her care.

During interview on 12/8/16, at 11:03 a.m. director of nursing (DON) stated MD-A should have been involved in finding care for R31 since he had refused to follow her as her primary physician.

The facility's Medical Director Agreement,

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21235	Continued From page 35 reviewed 1/29/16, identified the responsibilities to include the "Overall coordination of medical care in the facility to ensure the adequacy and appropriateness of the medical services provided to residents." SUGGESTED METHOD OF CORRECTION: The Medical Director or designee could develop, review, and/or revise policies and procedures to ensure appropriate resident care and services are being provided by physicians. The Medical Director designee could educate all appropriate staff on the policies and procedures. The Medical Director or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: 30 DAYS	21235		
21290	MN Rule 4658.0710 Subp. 3 A AdmissionOrders & Physician Evaluations Subp. 3. Frequency of physician evaluations. A. A resident must be evaluated by a physician at least once every 30 days for the first 90 days after admission, and then whenever medically necessary. A physician visit is considered timely if it occurs within ten days after the date the visit was required. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure that physician visits were provided at least once every 30 days for the first 90 days after admission for 1 of 5 residents (R31)	21290	Completed	1/17/17

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21290	Continued From page 36	21290		

who were newly admitted to the facility.

Findings include:

R31's admission minimum data set (MDS), dated 8/26/16, indicated no cognitive impairment.

R31's hospital discharge report, dated 8/19/16, indicated she had been admitted to the facility following a hospital stay related to leg pain. R31's diagnosis list, dated 12/7/16, identified an admission diagnoses of cellulitis (skin infection) along with a history of diabetes with nephropathy (kidney damage), heart failure, and chronic obstructive pulmonary disease.

A review of physician and physician assistant (PA) notes identified the following:

- On 8/31/16, R31 received a visit and was assessed by her from her primary physician. The note indicated that R31 needed monthly visits due to her "Advanced multiple co-morbid conditions with multiple medications" and that "Given long-term placement in skilled nursing facility will need to transfer care."

- 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.

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RN-A stated the situation was rare that the primary physician would stop seeing a patient when admitted 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 ultimately responsible for overseeing R31's care.

A facility copy of the Combined Federal and States Bill of Rights, dated 11/28/16, directed the facility would seek alternate physician services to "Assure provision of appropriate and adequate care and treatment."

Suggested Method of Correction: The director of nursing (DON) or designee could work with the medical director and administrator to ensure

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21290	Continued From page 38 physician coverage is provided the residents in the facility. The administrator, DON or designee could also perform audits of resident records to determine if the physician services had been provided. Time Period for Correction: Twenty-one (21) days.	21290		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and 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.	21390		1/17/17

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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.

Completed

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:

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

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Services reports dated 9/1/16, through 9/30/16, identified different cultures of collected specimens. The reports identified three different residents had urine samples cultured with the same bacteria, however lacked any information on the date of symptom onset, resolution, or if the infection was determined to be community or in-house acquired.

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.

OCTOBER 2016:

An Order Listing Report dated 12/5/16, identified six residents had received antibiotics during the month for different diagnosis which included chronic pain syndrome, pneumonia, yeast, and severe sepsis. The report lacked any dates of symptom onset or resolve, organism cultures, room numbers, or if the infection was determined to be community or in-house acquired.

An undated Infection Report Form identified a 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

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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 spreading in the facility.

There was no further information provided for any of the identified months of data.

When interviewed on 12/7/16, at 3:36 p.m. the director of nursing (DON) stated the person who had been in charge of the program was no longer employed at the facility and they were in the process of being reassigned to someone else to oversee. Further, the DON stated the infection control program lacked consistent monitoring, trending or analysis of the collected data adding,

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"We have to come to a better system," and, "Have better tracking of that [infections in the facility]." Further, the DON stated she had been aware the program was lacking these components for the past couple weeks.

During interview on 12/8/16, at 10:32 a.m. the administrator stated staff were, "Always watching" for infections during their regular meetings throughout the week, however do not start any processes for tracking or trending unless patterns of infection are being noted, "I look for the pattern."

A facility Infection Control Program policy dated 2/16/16, identified an objective which included, "Help prevent the development and transmission of disease and infection." The policy identified several elements of the facility program which included, "Surveillance based on systemic data collection," and having, "A system for detection, investigation, and control of outbreaks of infectious disease." Further, the policy identified summaries of the infections were to be compiled and analyzed by the infection control committee, with findings being communicated to determine if changes in practice or procedures were required.

HAND HYGIENE
R39's admission Minimum Data Set (MDS) dated 7/12/16, identified R39 was cognitively intact with a diagnosis of congestive heart failure and an right above the knee amputation. On 10/17/16, R39's significant change in status MDS identified R39 had an unstageable pressure ulcer on R39's left heel and another on his coccyx.
R39's treatment administration record identified a physician order on 11/04/16, for "Dressing change to left heel: Clean open area with normal saline, dry. Cover with Melgisorb dressing.

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21390	Continued From page 43 Change daily and on an as needed basis." During observation on 12/07/16, licensed practical nurse (LPN)-A donned a set of clean gloves. With her clean gloves, LPN-A took off the soiled bandage from R39's left heel and threw it in the trash. Without first removing her soiled gloves, LPN-A-A obtained a new bandage and accidentally dropped it on the floor. She grabbed the bandage off the floor and obtained a pen from her (LPN-A's) pocket to mark a date on the dressing without first removing her soiled gloves. With her same soiled gloves, LPN-A irrigated R39's left heel pressure ulcer. After irrigating R39's left heel, R39 placed his clean heel unto the soiled bed linen. With her same soiled gloves, she placed a new clean dressing over R39's left heel and then removed her soiled gloves. LPN-A than proceeded to wash her hands in R39's bathroom. When interviewed on 12/07/16, at 7:33 a.m. licensed practical nurse (LPN)-A stated she contaminated the pressure ulcer on R39's left heel after she (LPN-A) touched the ground and dug in her pocket with her gloved hands. LPN-A stated R39's heel should have not touched the bed after being irrigated because it increased R39's risk for an infection. Further, LPN-A stated it is important to don on a clean set of gloves when working with pressure ulcers because there was a higher risk of "contaminating " the area and an increased risk of infection. During interview on 12/07/16, at 11:18 a.m. the assistant director of nursing (ADON)-A stated wearing dirty gloves could contaminate the area and increased the risk of infection to R39's pressure ulcer on his left heel. When interviewed on 12/07/16, at 11:43 a.m. the director of nursing stated it was "inappropriate "	21390		

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21390	Continued From page 44 to wear soiled gloves during pressure ulcer treatment as it could increase the risk of infection to the pressure ulcer on R39's left heel. A policy regarding hand hygiene was requested, but not provided during the survey. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review their infection control program to ensure policies and procedures are established, inservice staff regarding policy and procedure, and audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		
21475	MN Rule 4658.1005 Subp. 1 Social Services: General Requirements Subpart 1. General requirements. A nursing home must have an organized social services department or program to provide medically related social services to each resident. A nursing home must make referrals to or collaborate with outside resources for a resident who is in need of additional mental health, substance abuse, or financial services. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide the necessary social services to assist residents in finding a physician for 1 of 1 residents (R31) who did not have a primary physician.	21475	Completed	1/17/17

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21475	Continued From page 45 Findings include: R31's admission minimum data set (MDS), dated 8/26/16, indicated no cognitive impairment. R31's hospital discharge report, dated 8/19/16, indicated she had been admitted to the facility following a hospital stay related to leg pain, which also indicated a follow up appointment with her primary physician at the facility in one week. R31's diagnosis list, dated 12/7/16, further identified an admission diagnosis of cellulitis (skin infection) along with a history of diabetes with nephropathy (kidney damage), heart failure, and chronic obstructive pulmonary disease. Review of physician and physician assistant (PA) notes identified the following: On 8/31/16, R31 received a visit and was assessed by her primary medical doctor (MD-B). The note indicated that R31 needed monthly visits due to her "Advanced multiple comorbid conditions with multiple medications" and that "Given long-term placement in skilled nursing facility will need to transfer care." On 10/17/16, 47 days after her last physician visit, R31 had an appointment to establish care with a different physician, MD-C outside the facility who assessed R31. The note identified MD-C would be contacting the facility to "Clarify the issue concerning R31's non-eligibility for in-facility care." On 10/24/16, MD-C declined to take R31 as a patient recommending an Internal Medicine Provider, and offered to place referral for the facility. On 11/3/16, 76 days after her admission, R31 had an appointment with a PA-A. After assessing	21475		

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R31, the PA-A also declined to take R31 as a patient due to her complex medical history and recommended an Internal Medicine Physician.

On 11/18/16, 91 days after she was admitted, R31 had an appointment with a MD-D outside the facility who completed an assessment of R31 and became her primary physician.

R31's medical record lacked any indication social services was involved in assisting R31 to establish care with a primary physician while a resident at the nursing the facility.

During interview on 12/7/16, at 5:29 p.m. medical director (MD)-A stated he was unaware R31 was not assessed by a physician in September or that she had subsequently been denied care twice. MD-A stated it was the responsibility of R31's primary physician to continue care until a replacement physician was found. However, after R31 was denied care from her primary physician, he would have expected the facility's social services to aide in finding R31 an appropriate physician.

During interview on 12/8/16, at 11:03 a.m. social worker (SW)-A stated residents were typically followed by their primary physician, unlike R31's situation. SW-A stated she thought the nursing staff were working on finding R31 a new physician and social services did not have any role in assisting R31 to find a physician.

SUGGESTED METHOD OF CORRECTION:
The social worker or designee, could review and/or revise facility policies and procedures related to medically related social services. Responsible personnel could be re-educated on these policies and procedures. Appropriate

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21475	Continued From page 47 efforts could be made toward supporting the social service needs of the individual(s) identified in the deficiency, with supporting documentation maintained. Other residents could be evaluated for social service needs. An auditing system could be developed and implemented, with results shared with the facility's Quality Assessment & Assurance committee, to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21475		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA.	21540		1/17/17

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21540	Continued From page 48 This MN Requirement is not met as evidenced by: Based on interview, and document review, the facility failed to ensure non-pharmacological interventions and behavior monitoring were completed prior to administering anti-anxiety medications for 1 of 5 residents (R80) reviewed for unnecessary medications. Findings include: R80's quarterly Minimum Data Set (MDS) dated 08/11/16, indicated R80 had no cognitive impairment with a diagnosis of major depressive and anxiety disorder. R80's Care Area Assessment (CAA) dated 11/15/16, noted R80 had no behaviors or psychosis and required extensive assistance of one with activities of daily living (ADL's). R80's care plan dated 02/23/16, indicated R80 had an identified problem of, "Resident uses anti-anxiety medications [Ativan] related to anxiety disorder." Interventions for R80 included; monitor/record occurrence for behaviors symptoms and document per facility protocol. There was no indication of how R80's exhibited her anxiety. During observation on 12/6/16 between 1:45 p.m. to 2:28 p.m. R80 exhibited no outward signs of anxiety. During observation on 12/7/16 from 6:00 a.m. to 8:30 a.m., R80 presented no signs of anxiety. Review of R80's medication administration record (MAR) indicated R80 had an order for lorazepam (medication used to treat anxiety) 0.25 milligrams	21540	Completed	

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21540	Continued From page 49 (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. In September 2016, R80 took her as needed lorazepam on 10 different occasions. During the above episodes no signs of anxiety, or non-pharmacological interventions were attempted prior to the use of the medication. In October 2016, R80 received 7 doses of lorazepam, and signs of anxiety, or non-pharmacological interventions were attempted prior to the use of the medication. There was no indication of why the medication was being given. In November 2016, R80 took 6 doses of lorazepam and signs of anxiety, or non-pharmacological interventions were attempted prior to the administration of the medication. Review of R80's pharmacist drug regimen review on 01/20/16, the consultant pharmacist (CP) indicated facility staff needed to document behaviors, non-pharmacological approaches attempted and effectiveness for R80's as needed lorazepam. On 11/14/16, the CP again indicated the documentation on R80's lorazepam needed	21540		

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21540	Continued From page 50	21540		

to include behaviors and non-pharmacological interventions.

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.

When interviewed on 12/07/16, the director of nursing (DON) stated it was important for facility staff to document non-pharmacological interventions and behaviors "to evaluate" the effectiveness of the as needed lorazepam. There is no rational for the use of this medication at the current dose for R80.

Review of an undated facility policy titled, "Psychotropic Medication Use Guidelines", identified all anti-anxiety medication administered to residents required facility staff to " quantitatively and objectively" document behaviors symptoms.

A SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures to ensure that residents do not receive unnecessary medications, ensure all medications include parameters, and educate all relevant staff. The DON or designee can develop monitoring systems to ensure ongoing compliance and report the findings to the Quality Assurance Committee.

TIME PERIOD FOR CORRECTION: Fourteen (14) days.

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21550	MN Rule 4658.1325 Subp. 1 Adminiatration of Medications; Pharmacy Serv. Subpart 1. Pharmacy services. A nursing home must arrange for the provision of pharmacy services. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medications were given according to manufactures instructions for 1 of 1 residents (R94). Findings include: 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 of the mouth. R94's Dismissal Summary from Mayo Clinic dated 12/1/16, indicated R94 had dysphagia (difficulty swallowing) and had a peg (percutaneous endoscopic gastrostomy, which is placed in abdominal wall and stomach to allow nutrition, fluids and/or medications to put directly into the stomach, bypassing the mouth and esophagus) tube placed. Further, R94 was to receive myrbetriq (medication for treatment of overactive bladder) 25 milligrams (mg) sustained release (designed to release medication in body over a extended period of time) by mouth every morning. A speech therapy (ST) Plan Of Care, dated	21550	Completed	1/17/17

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12/02/16, indicated R94 was unable to swallow on command and had no spontaneous swallow noted.

During observation 12/07/16, at 10:40 a.m. listened practical nurse (LPN)- D set up R94's medications. LPN-A crushed all of R94's medications except for THE myrbetriq. LPN-D stated the medication was "sustained released" and could not be crushed, and was ordered to be given by mouth. LPN-D entered R94's room and administered R94's medications, except myrbetriq, via peg tube. LPN-A then stated she would not be able to give R94 myrbetriq because she was uncertain if R94 could swallow the pill.

During interview 12/07/16, at 1:00 p.m. LPN-D stated she spoke with R94's physician who discontinued myrbetriq. LPN-D also stated R94 had received the myrbetriq five times since admission, but was uncertain how the staff administered this medication to R94.

During interview 12/08/16, at 9:15 a.m. the director of nursing (DON) stated the staff must have been giving the myrbetriq by crushing it, and administering it via the peg tube. The DON stated the nurses should have clarified this order with R94's physician.

During a subsequent interview on 12/08/16, at 9:21 a.m. LPN-D stated she had given R94 myrbetriq by crushing it and giving it via R94's peg tube.

A facility policy was requested on giving medications according to manufacture specifications and was not received.

A Patient Information from the manufacture

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21550	Continued From page 53 Astellas Pharma US, Inc. revised August 2016, instructed patients "You should take Mybetriq with water and swallow the tablet whole. Do not crush or chew the tablet". SUGGESTED METHOD OF CORRECTION: The director of nursing and or pharmacist can educate all staff responsible for medication storage to remove outdated medications to prevent unwanted use by resident/s, and ensure medication is provided according to manufacture recommendations. The DON or designee can develop monitoring systems to ensure ongoing compliance and report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21550		
21705	MN Rule 4658.1415 Subp. 6 Plant Housekeeping, Operation, & Maintenance Subp. 6. Heating, air conditioning, and ventilation. A nursing home must operate and maintain the mechanical systems to provide comfortable and safe temperatures, air changes, and humidity levels. Temperatures in all resident areas must be maintained according to items A to C: A. For construction of a new physical plant, a nursing home must maintain a temperature range of 71 degrees Fahrenheit to 81 degrees Fahrenheit at all times. B. For existing facilities, a nursing home must maintain a minimum temperature of 71 degrees Fahrenheit during the heating season. C. Variations of the temperatures required by items A and B are allowed if the variations are	21705		1/17/17

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21705	Continued From page 54 based on documented resident preferences. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide housekeeping and maintenance services necessary to maintain comfortable temperatures 2 of 5 resident rooms (R162, R165) and one or three resident dayrooms reviewed in the facility, which had the potential to affect 50 residents who used these areas. Findings include: During observation on 12/08/16, at 12:47 p.m. an environmental tour of the facility was conducted with maintenance supervisor (MS) who confirmed the following findings: The resident dayroom, located off of the main dining room, was cool. The temperature measured at 66 degrees Fahrenheit (F). In R162, the temperature in the room measured at 70 degrees F. In R167 the temperature in the room measured at 66 degrees F. On 12/08/16, at 1:03 p.m. MS confirmed all of the findings listed above. MS stated the usual facility practice was for facility staff to notify maintenance with concerns with paper slips, which were picked up in the morning and as needed by the maintenance staff. Further, MS stated he had not checked resident or common area room temperatures in over a month because he did not "have time," and was working on getting around to it.	21705	Completed	

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21705	Continued From page 55 A policy on facility maintenance was requested, but was not provided during the survey. Suggested Method of Correction: The director of facility operations (DOF) operations or designee could work with the administrator to update policies and procedures for when to regulate heat for the resident rooms, and ensure a process to monitor resident room temperatures. The DON or designee could perform audits of resident rooms to determine if the temperature is adequate. Time Period for Correction: Fourteen (14) days.	21705		
21800	MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current	21800		1/17/17

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21800	Continued From page 56 facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide the appropriate liability notice to 2 of 6 residents (R64 and R91) reviewed who were discharged from Medicare services. Findings include: R64's admission Minimum Data Set (MDS), dated 10/28/16, indicated he received physical and occupation therapy while admitted in the facility. R64's was provided and signed a Notice of Medicare Non-Coverage CMS 10095 (which explains a resident's right to an immediate appeal through the QIO or Quality Improvement Organization on 11/4/16, identifying his Medicare services where ending on 11/7/16. R64 was discharged from the facility on 11/8/16. R64's received notice form CMS 10095, which identified Straits Health as the QIO. R64 should have received the form CMS 10123, and not the CMS 10095, which was the incorrect form. R91's admission MDS, dated 11/18/16, indicated he received physical and occupation therapy while a resident in the facility. R91 was a current	21800	Completed	

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21800	Continued From page 57 resident at the facility. R91 received and signed liability notice form CMS 10095 on 11/22/16, regarding Medicare services ending on 11/24/16. Since R91 remained in the facility, he also received the a SNF determination on continued stay (which explains a resident's financial obligations when Medicare services end). R91 should have received the form CMS 10123, and not the CMS 10095, which was the incorrect 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 CMS 10095 form, expired 10/31/2013, over three years ago. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop, review, and/or revise policies and procedures to ensure staff are educated on the appropriate liability notices to provide residents at the end of Medicare services, and to ensure resident rights are communicated appropriately and acted upon. The administrator or designee could educate all appropriate staff on the policies and procedures	21800		

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21800	Continued From page 58 and develop a monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	21800		
21855	MN St. Statute 144.651 Subd. 15 Patients & Residents of HC Fac.Bill of Rights Subd. 15. Treatment privacy. Patients and residents shall have the right to respectfulness and privacy as it relates to their medical and personal care program. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discreetly. Privacy shall be respected during toileting, bathing, and other activities of personal hygiene, except as needed for patient or resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure personal privacy was provided by staff for 1 of 5 residents (R94) who were dependent upon staff for activities of daily living. Findings include: R94's Admission Record, undated, indicated R94 had dementia and a neurological disease. The individual Resident Care Plan dated 12/1/16, indicated R94 needed staff assistance with dressing, bathing and grooming. During observation 12/05/16, at 7:09 p.m. R94 was lying in bed with her sheets pulled down.	21855	Completed	1/17/17

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21855	Continued From page 59	21855		

R94 was lying on her left side, with her hospital gown completely open in the back, exposing her bare back and buttocks with an incontinent product. R94's door was completely open to the hallway, as staff and visitors walked past. Numerous staff were observed walking by R94's room, but made no attempts to assist R94 to cover herself or close the door to maintain R94's privacy.

During interview on 12/05/16, 7:20 p.m. licensed practical nurse (LPN)-A stated R94 "fidgets around" and must have pulled off her sheets. LPN-A stated (R94) should not have been left uncovered for others to see.

During observation 12/06/16, at 7:55 a.m., R94 was lying in bed, with the room door completely open, exposing her back side. R94 wore an incontinent product, which had fallen down and exposed the top of her buttocks. Staff walked by R94's room, and an unidentified nurse was administering medication from the cart parked just outside of R94's room. Staff made no attempts to cover R94, or close her door to ensure R94's personal privacy.

During interview 12/08/16, at 9:31 a.m. the director of nursing (DON), stated staff should have provided privacy and attempted to keep R94 covered. The DON stated the facility will be working on educating the staff on privacy.

A policy was requested for privacy and was not provided.

SUGGESTED METHOD OF CORRECTION:
The Director of Nursing Services or designee could develop, review, and/or revise policies and procedures to ensure all residents' privacy is

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21855	Continued From page 60 maintained. The Director of Nursing Services or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing Services or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21855		
21942	MN St. Statute 144A.10 Subd. 8b Establish Resident and Family Councils Resident advisory council. Each nursing home or boarding care home shall establish a resident advisory council and a family council, unless fewer than three persons express an interest in participating. If one or both councils do not function, the nursing home or boarding care home shall document its attempts to establish the council or councils at least once each calendar year. This subdivision does not alter the rights of residents and families provided by section 144.651, subdivision 27. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to establish a family council for the nursing facility this had the potential to affect all 70 residents who resided in the facility. Findings include: A review of documents provided to the survey team indicated the facility attempted to establish a family council. A letter invited people to a	21942	Completed	1/17/17

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"Family Interest Group" whose purpose was "...to give family and friends a voice in decisions that affect their loved ones..." The letter, undated, indicate a meeting date of May 13, 2015, along with agenda items.

In an interview on 12/7/16 at 4:04 p.m., the facility administrator said the the family council was discussed on a call to the facility's management in early November. The administrator also said the interdisciplinary team at the facility discussed, and decided, with the holidays coming up, to try to get a council going after the holiday season. The administrator stated we needed to get Talahi to a place where we are comfortable, and to that point, our efforts were best invested to bring the facility "up to compliance" and wit until after the holidays to make an attempt to re-establish the council. The administrator acknowledged no movement on the council since May of 2015. The administrator, denied putting the establishment of the council on the back burner, but insisted there were a lot of extenuating circumstances this past year. The administrator felt there was a better chances to establish the council after the holidays, and stated "It was not on the calendar this year."

A review of a facility document "Outline for Weekly Admin (administration)/COO (chief operating officer) Call, dated 11/7/2016, indicated the words "family council" under the Admissions/Marketing section. The facility provided no further documentation regarding the establishment of a family council.

SUGGESTED METHOD OF CORRECTION: The facility could send a letter out to all family members, and/or talk to all family members to see if a family council program can be developed.

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00614	A. BUILDING: ______ B. WING ______	C 12/08/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21942	Continued From page 62 TIME PERIOD OF CORRECTION: Twenty (21) days	21942		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section	21980		1/17/17

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00614	A. BUILDING: ______ B. WING ______	C 12/08/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21980	Continued From page 63 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of abuse and injuries of unknown origin were immediately reported to the administrator and/or state agency (SA) and were thoroughly investigated for 2 of 5 residents (R97 and R33) whose allegations of abuse incidents were reviewed. Findings include: R97's significant change MDS dated 05/18/16, indicated she was severely, cognitively impaired and had no behaviors. R97's care plan dated 3/17/16, indicated she had diagnoses of altered mental status and depression. A Risk Management Report, dated 6/9/16 at 10:20 a.m. indicated during a bath, R97 had a bruise on the top of her left hand that measured 6 centimeters (cm) by 4 cm, and was blue, with a 1 cm dark, purple area in the center. The report	21980	Completed	

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00614	A. BUILDING: ____ B. WING ____	C 12/08/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21980	Continued From page 64	21980		

further indicated R97 had no complaints of pain and when asked if she bumped it, R97 smiled and nodded. There was no indication the administrator and state agency were immediately notified of the injury of known origin, nor was a thorough investigation completed to determine the possible cause of the injury.

During interview on 12/07/16, at 11:00 a.m. the administrator was unable to recall the incident. She thought since R97 nodded her head and smiled after being asked if she bumped it, this was probably why the incident was not reported. The administrator then stated if the resident is cognitively impaired the report should have been reported immediately reported to her, SA and then investigated.

R33's quarterly MDS dated 09/06/16, indicated she was severely cognitively impaired. R33's care plan dated 03/02/15, indicated she had impaired thought processes and cognitive status, secondary to Alzheimer's disease, and had difficulty verbalizing needs.

A Incident Report dated 11/15/16, indicated nursing assistant (NA)-H reported to registered nurse (RN)-B that a possible abuse incident allegedly took place during the morning of 11/12/16, with an alleged perpetrator, whom was immediately suspended. NA-H reported she was rough while grabbing R33 by the forearms during morning cares on 11/12/16. R33 was examined, and two bruises were found on her left forearm, on the top of her arm measuring two cm by four cm; and one on the underside of her arm measuring 2 cm by 2 cm. There were also bruises located on R33's right forearm, measuring 2 cm by 4.5 cm, and the one on the

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00614	A. BUILDING: ______ B. WING ______	C 12/08/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21980	Continued From page 65	21980		

underside measured 2 cm by 2.5 cm. The report indicated the incident was reported to the state agency on 11/15/16, three days after the incident occurred. There was no indication the administrator and state agency was immediately notified of the incident.

During interview 12/07/16, at 11:15 a.m. the facility administrator stated the incident "should have been" immediately reported to her and the 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.

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00614	A. BUILDING: ______ B. WING ______	C 12/08/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21980	Continued From page 66 TIME PERIOD OF CORRECTION: Ten (10) days	21980		

REVISED

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: J6VE
Facility ID: 00614

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245438**
2. STATE VENDOR OR MEDICAID NO. (L2) **885463000**

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

4. TYPE OF ACTION: 7 (L8)
1. Initial **2. Recertification** **3. Termination** **4. CHOW** **5. Validation** **6. Complaint** **7. On-Site Visit** **9. Other** **8. Full Survey After Complaint**

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **06/01/2013**
6. DATE OF SURVEY **02/07/2017** (L34)
8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC 2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital **05 HHA** **09 ESRD** **13 PTIP** **22 CLIA** **02 SNF/NF/Dual** **06 PRTF** **10 NF** **14 CORF** **03 SNF/NF/Distinct** **07 X-Ray** **11 ICF/IID** **15 ASC** **04 SNF** **08 OPT/SP** **12 RHC** **16 HOSPICE**

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

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

12.Total Facility Beds **77** (L18)
13.Total Certified Beds **77** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Michelle Thompson, HFE NE II 02/07/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 03/16/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **02/01/1987** (L24)
23. LTC AGREEMENT BEGINNING DATE (L41)
24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

Posted 03/24/2017 Co.

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **01/23/2017** (L33)

DETERMINATION APPROVAL

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.

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.

Sincerely,

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

Enclosure
cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245438	A. Building B. Wing	2/7/2017

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0164 Reg. # 483.10(h)(1)(3)(i); 483.70(i)(2) LSC	Correction Completed 01/02/2017	ID Prefix F0167 Reg. # 483.10(g)(10)(i)(11) LSC	Correction Completed 01/17/2017	ID Prefix F0225 Reg. # 483.12(a)(3)(4)(c)(1)-(4) LSC	Correction Completed 01/17/2017
ID Prefix F0226 Reg. # 483.12(b)(1)-(3), 483.95(c)(1)-(3) LSC	Correction Completed 01/17/2017	ID Prefix F0250 Reg. # 483.40(d) LSC	Correction Completed 01/17/2017	ID Prefix F0257 Reg. # 483.10(i)(6) LSC	Correction Completed 01/17/2017
ID Prefix F0280 Reg. # 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) LSC	Correction Completed 01/17/2017	ID Prefix F0281 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 01/17/2017	ID Prefix F0282 Reg. # 483.21(b)(3)(ii) LSC	Correction Completed 01/17/2017
ID Prefix F0312 Reg. # 483.24(a)(2) LSC	Correction Completed 01/17/2017	ID Prefix F0314 Reg. # 483.25(b)(1) LSC	Correction Completed 01/17/2017	ID Prefix F0315 Reg. # 483.25(e)(1)-(3) LSC	Correction Completed 01/17/2017
ID Prefix F0323 Reg. # 483.25(d)(1)(2)(n)(1)-(3) LSC	Correction Completed 01/17/2017	ID Prefix F0329 Reg. # 483.45(d) LSC	Correction Completed 01/17/2017	ID Prefix F0353 Reg. # 483.35(a)(1)-(4) LSC	Correction Completed 01/17/2017

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) BF/KJ	DATE 03/14/2017	SIGNATURE OF SURVEYOR 28598	DATE 02/07/2017
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245438	A. Building B. Wing	2/7/2017

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0365 Reg. # 483.60(d)(3) LSC	Correction Completed 01/17/2017	ID Prefix F0371 Reg. # 483.60(i)(1)-(3) LSC	Correction Completed 01/17/2017	ID Prefix F0387 Reg. # 483.30(c)(1)(2) LSC	Correction Completed 01/17/2017
ID Prefix F0425 Reg. # 483.45(a)(b)(1) LSC	Correction Completed 01/17/2017	ID Prefix F0431 Reg. # 483.45(b)(2)(3)(g)(h) LSC	Correction Completed 01/17/2017	ID Prefix F0441 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 01/17/2017
ID Prefix F0501 Reg. # 483.70(h)(1)(2) LSC	Correction Completed 01/17/2017				

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) BF/KJ	DATE 03/14/2017	SIGNATURE OF SURVEYOR 28598	DATE 02/07/2017
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
12/8/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF 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

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00614 (Y1)	A. Building 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 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 (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)
ID Prefix 20565 Reg. # MN Rule 4658.0405 Subp. 3 LSC	Correction Completed 02/07/2017	ID Prefix 20570 Reg. # MN Rule 4658.0405 Subp. 4 LSC	Correction Completed 02/07/2017	ID Prefix 20800 Reg. # MN Rule 4658.0510 Subp. 1 LSC	Correction Completed 02/07/2017
ID Prefix 20830 Reg. # MN Rule 4658.0520 Subp. 1 LSC	Correction Completed 02/07/2017	ID Prefix 20835 Reg. # MN Rule 4658.0520 Subp. 2 A LSC	Correction Completed 02/07/2017	ID Prefix 20900 Reg. # MN Rule 4658.0525 Subp. 3 LSC	Correction Completed 02/07/2017
ID Prefix 20910 Reg. # MN Rule 4658.0525 Subp. 5 A.B LSC	Correction Completed 02/07/2017	ID Prefix 21235 Reg. # MN Rule 4658.0700 Subp. 2 C LSC	Correction Completed 02/07/2017	ID Prefix 21290 Reg. # MN Rule 4658.0710 Subp. 3 A LSC	Correction Completed 02/07/2017
ID Prefix 21390 Reg. # MN Rule 4658.0800 Subp. 4 A-I LSC	Correction Completed 02/07/2017	ID Prefix 21475 Reg. # MN Rule 4658.1005 Subp. 1 LSC	Correction Completed 02/07/2017	ID Prefix 21540 Reg. # MN Rule 4658.1315 Subp. 2 LSC	Correction Completed 02/07/2017
ID Prefix 21550 Reg. # MN Rule 4658.1325 Subp. 1 LSC	Correction Completed 02/07/2017	ID Prefix 21705 Reg. # MN Rule 4658.1415 Subp. 6 LSC	Correction Completed 02/07/2017	ID Prefix 21800 Reg. # MN St. Statute144.651 Subd. 4 LSC	Correction Completed 02/07/2017

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) BF/KJ	DATE 03/14/2017	SIGNATURE OF SURVEYOR 28598	DATE 02/07/2017
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00614 (Y1)	A. Building 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 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 Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 21855 Reg. # MN St. Statute 144.651 Subd. 15 LSC	Correction Completed 02/07/2017	ID Prefix 21942 Reg. # MN St. Statute 144A.10 Subd. 8b LSC	Correction Completed 02/07/2017	ID Prefix 21980 Reg. # MN St. Statute 626.557 Subd. 3 LSC	Correction Completed 02/07/2017

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	BF/KJ	03/14/2017	28598	02/07/2017
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
12/8/2016

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: J6VE
Facility ID: 00614

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245438**
2. STATE VENDOR OR MEDICAID NO. (L2) **885463000**

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

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **06/01/2013**
6. DATE OF SURVEY **12/08/2016** (L34)
8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC 2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital 05 HHA 09 ESRD 13 PTIP 22 CLIA
02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF
03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC
04 SNF 08 OPT/SP 12 RHC 16 HOSPICE

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

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

12. Total Facility Beds **77** (L18)
13. Total Certified Beds **77** (L17)

10. THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Michelle Thompson, HFE NE II 01/06/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 01/23/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **02/01/1987** (L24)
23. LTC AGREEMENT BEGINNING DATE (L41)
24. LTC AGREEMENT ENDING DATE (L25)

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

25. LTC EXTENSION DATE: (L27)

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

Posted 01/23/2017 Co.

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

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:

> Opportunity to Correct **- 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:

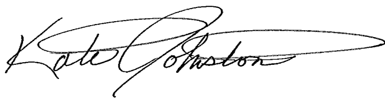
http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245438	A. BUILDING ______ B. WING ______	C 12/08/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 12/5/16 to 12/8/16, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH). Talahi Nursing & Rehab Center was found to not be in compliance with the regulations at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. In addition, an investigation of complaint H5438047 was completed and substantiated with a deficiency cited at F353 during the survey. An investigation of complaint H5438046 was completed, and found to be unsubstantiated.	F 000		
F 164 SS=D	483.10(h)(1)(3)(i); 483.70(i)(2) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS 483.10 (h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. (h)(3)The resident has a right to secure and confidential personal and medical records.	F 164		1/17/17

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

Electronically Signed | | 01/04/2017

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

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F 164	Continued From page 1 (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. §483.70 (i) Medical records. (2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure personal privacy was provided by staff for 1 of 5 residents (R94) who was dependent upon staff for activities of daily living. Findings include:	F 164	F000: Preparation and/or execution of this report of correction does not constitute admission or agreement by the provider of the truth of the facts set forth in the statement of deficiencies required by the provisions of the federal and state law.	

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F 164	Continued From page 2 R94's Admission Record, undated, indicated R94 had dementia and a neurological disease. The individual Resident Care Plan dated 12/1/16, indicated R94 needed staff assistance with dressing, bathing and grooming. During observation 12/05/16, at 7:09 p.m. R94 was lying in bed with her sheets pulled down. R94 was lying on her left side, with her hospital gown completely open in the back, exposing her bare back and buttocks with an incontinent product. R94's door was completely open to the hallway, as staff and visitors walked past. Numerous staff were observed walking by R94's room, but made no attempts to assist R94 to cover herself or close the door to maintain R94's privacy. During interview on 12/05/16, 7:20 p.m. licensed practical nurse (LPN)-A stated R94 "fidgets around" and must have pulled off her sheets. LPN-A stated (R94) should not have been left uncovered for others to see. During observation 12/06/16, at 7:55 a.m., R94 was lying in bed, with the room door completely open, exposing her back side. R94 wore an incontinent product, which had fallen down and exposed the top of her buttocks. Staff walked by R94's room, and an unidentified nurse was administering medication from the cart parked just outside of R94's room. Staff made no attempts to cover R94, or close her door to ensure R94's personal privacy. During interview 12/08/16, at 9:31 a.m. the director of nursing (DON), stated staff should have provided privacy and attempted to keep R94	F 164	F164- Personal Privacy of Records It is the policy of Talahi Nursing and Rehab Center provide personal privacy for its residents. The policy has been reviewed, and is accurate. R94 has been relocated to room 171-2 which is located in a low traffic area but close to the nurse's station. Staff have been re-educated on the policy to assure privacy for all residents at all times. See Exhibit 164A. Random audits will be completed three times per week for three weeks to assure privacy is protected. IDT/QAPI will evaluate outcome of these audits at the completion of three weeks and determine appropriate action to follow. See Exhibit 164B DON/designee is responsible	

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F 164	Continued From page 3 covered. The DON stated the facility will be working on educating the staff on privacy. A policy was requested for privacy and was not provided.	F 164		
F 167 SS=C	483.10(g)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 167	F167-Servey Results	1/17/17

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F 167	Continued From page 4 review, the facility failed to ensure the most recent State agency survey results were available to review. This had potential to affect all 70 residents, visitors and staff who wished to review this information. Findings include: During the initial tour of the facility on 12/5/16, at 11:55 a.m., a blue-colored binder labeled, "MN [Minnesota] Dept [Department] of Health Survey Results" was found on the West nursing station. The survey results contained inside were dated, 12/16/14 (nearly two years prior). There was no additional surveys identified in the binder to review. When interviewed on 12/5/16, at 12:27 p.m. health unit coordinator (HUC)-A stated the results in the binder were not the most recently completed survey. HUC-A and the surveyor then toured the building and were unable to locate any additional survey results. During interview on 12/5/16, at 12:29 p.m. receptionist (R)-A stated the blue binder was used to house the most recent survey results and was typically kept at the front desk. When interviewed on 12/5/16, at 12:31 p.m. the administrator stated the blue binder was used to house the most recent survey results, "This is it," and the survey results inside were not the most current adding, "That's not the right survey." During subsequent interview on 12/5/16, at 3:29 p.m. the administrator stated the most recent survey results were placed in a different binder and accidentally put behind the front desk and was not accessible to residents or visitors.	F 167	Talahi Nursing and Rehab Center does post the results of the most recent survey of the facility in a readily accessible place for residents, family members and legal representatives of residents. The most current survey is located on the reception desk in the front lobby, and the receptionist is responsible to assure its location on a daily basis when she is here. This was addressed immediately when pointed out by surveyor. The receptionist maintains a calendar audit check off which confirms the survey book is located on the reception desk in the front lobby. The Administrator confirms accurate placement and maintenance of the calendar check for accurate placement of the survey book. QAPI will review these audits at its regularly held meetings and will determine an appropriate schedule for ongoing audits A directed in-service was conducted by the Administrator by the Regional Director of Operation on compliance and adherence to ensure the most recent survey results are available at all times. The administrator is responsible to ensure compliance regularly.	

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

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F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS (a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if	F 225		1/17/17

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	245438	A. BUILDING ______ B. WING ______	C 12/08/2016

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F 225 Continued From page 6 F 225

the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

(2) Have evidence that all alleged violations are thoroughly investigated.

(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to ensure allegations of abuse and injuries of unknown origin were immediately reported to the administrator and/or state agency (SA) and were thoroughly investigated for 2 of 5 residents (R97 and R33) whose allegations of abuse incidents were reviewed.

Findings include:

R97's significant change MDS dated 05/18/16, indicated she was severely, cognitively impaired and had no behaviors. R97's care plan dated 3/17/16, indicated she had diagnoses of altered

F225- Investigate Allegations

It is the policy of Talahi Nursing and Rehab Center to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in bodily injury, or not later that 24 hours if the events that cause the allegation do not involve abuse and do not

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F 225

Continued From page 7

mental status and depression.

A Risk Management Report, dated 6/9/16 at 10:20 a.m. indicated during a bath, R97 had a bruise on the top of her left hand that measured 6 centimeters (cm) by 4 cm, and was blue, with a 1 cm dark, purple area in the center. The report further indicated R97 had no complaints of pain and when asked if she bumped it, R97 smiled and nodded. There was no indication the administrator and state agency were immediately notified of the injury of known origin, nor was a thorough investigation completed to determine the possible cause of the injury.

During interview on 12/07/16, at 11:00 a.m. the administrator was unable to recall the incident. She thought since R97 nodded her head and smiled after being asked if she bumped it, this was probably why the incident was not reported. The administrator then stated if the resident is cognitively impaired the report should have been reported immediately reported to her, SA and then investigated.

R33's quarterly MDS dated 09/06/16, indicated she was severely cognitively impaired. R33's care plan dated 03/02/15, indicated she had impaired thought processes and cognitive status, secondary to Alzheimer's disease, and had difficulty verbalizing needs.

A Incident Report dated 11/15/16, indicated nursing assistant (NA)-H reported to registered nurse (RN)-B that a possible abuse incident allegedly took place during the morning of 11/12/16, with an alleged perpetrator, whom was immediately suspended. NA-H reported she was

F 225 (Plan of Correction)

result in serious bodily injury, to the administrator of the facility and to other officials(including the state survey agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

The occurrences of R97 and R33 were reviewed by the IDT, and completed.

The policy and procedure for vulnerable adult was reviewed and is current.

All suspected vulnerable adult reports are reported to the DON and Administrator per policy guidelines.

DON/Administrator or designee will complete daily audit of progress notes and risk management/incident report log to ensure update immediately of all incidents and potential VA reports.

An audit tool for vulnerable adult reports was created and is in use to ensure for timely notification and completion of investigation. This tool and the findings will be reviewed weekly and the monthly QA meetings.

Administrator, DON/designee are responsible

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F 225	Continued From page 8 rough while grabbing R33 by the forearms during morning cares on 11/12/16. R33 was examined, and two bruises were found on her left forearm, on the top of her arm measuring two cm by four cm; and one on the underside of her arm measuring 2 cm by 2 cm. There were also bruises located on R33's right forearm, measuring 2 cm by 4.5 cm, and the one on the underside measured 2 cm by 2.5 cm. The report indicated the incident was reported to the state agency on 11/15/16, three days after the incident occurred. There was no indication the administrator and state agency was immediately notified of the incident. During interview 12/07/16, at 11:15 a.m. the facility administrator stated the incident "should have been" immediately reported to her and the 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.	F 225		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F 226		1/17/17

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F 226	Continued From page 9 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement their abuse prohibition policy and procedure to immediately report allegation of abuse and injuries of unknown origin to the administrator, state agency and conduct a	F 226	F226- Develop Abuse Policies It is the policy of Talahi Nursing and Rehab Center to ensure that all alleged violations involving abuse, neglect,	

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F 226	Continued From page 10 thorough investigation for 2 of 5 resident (R97 and R33) allegations that were reviewed. Findings include: 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 to call the administrator immediately. The policy further indicated an internal facility investigation of reports will be completed. R97's significant change MDS dated 05/18/16, indicated she was severely, cognitively impaired and had no behaviors. R97's care plan dated 3/17/16, indicated she had diagnoses of altered mental status and depression. A Risk Management Report, dated 6/9/16 at 10:20 a.m. indicated during a bath, R97 had a bruise on the top of her left hand that measured 6 centimeters (cm) by 4 cm, and was blue, with a 1 cm dark, purple area in the center. The report further indicated R97 had no complaints of pain and when asked if she bumped it, R97 smiled and nodded. There was no indication the administrator and state agency were immediately notified of the injury of known origin, nor was a thorough investigation completed to determine the possible cause of the injury, according to the facility policy. During interview on 12/07/16, at 11:00 a.m. the	F 226	exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the Administrator of the facility and to other officials (including the state survey agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with state law through established procedures. The occurrences of R97 and R33 were reviewed by the IDT, and completed. The policy and procedure for vulnerable adult was reviewed and is current. All suspected vulnerable adult reports are reported to the DON and Administrator per policy guidelines. Staff have been re-educated on the vulnerable adult reporting and procedure and reporting guidelines. DON/Administrator or designee will complete daily audit of progress notes and risk management/incident report log to ensure update immediately of all incidents and potential VA reports. An audit tool of vulnerable adult reports was created and is in use to ensure for	

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F 226	Continued From page 11 administrator was unable to recall the incident. She thought since R97 nodded her head and smiled after being asked if she bumped it, this was probably why the incident was not reported. The administrator then stated if the resident is cognitively impaired the report should have been reported immediately reported to her, SA and then investigated, as their policy identified. R33's quarterly MDS dated 09/06/16, indicated she was severely cognitively impaired. R33's care plan dated 03/02/15, indicated she had impaired thought processes and cognitive status, secondary to Alzheimer's disease, and had difficulty verbalizing needs. A Incident Report dated 11/15/16, indicated nursing assistant (NA)-H reported to registered nurse (RN)-B that a possible abuse incident allegedly took place during the morning of 11/12/16, with an alleged perpetrator, whom was immediately suspended. NA-H reported she was rough while grabbing R33 by the forearms during morning cares on 11/12/16. R33 was examined, and two bruises were found on her left forearm, on the top of her arm measuring two cm by four cm; and one on the underside of her arm measuring 2 cm by 2 cm. There were also bruises located on R33's right forearm, measuring 2 cm by 4.5 cm, and the one on the underside measured 2 cm by 2.5 cm. The report indicated the incident was reported to the state agency on 11/15/16, three days after the incident occurred. There was no indication the administrator and state agency was immediately notified of the incident, as directed by their policy. During interview 12/07/16, at 11:15 a.m. the	F 226	timely notification and completion of investigation. This tool and the findings will be reviewed weekly and at the monthly QA meetings. Administrator, DON/designee are responsible	

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F 226	Continued From page 12 facility administrator stated the incident "should have been" immediately reported to her and the SA on 11/12/16, but a staff member waited until 11/15/16 to report the incident. The administrator reported once she was notified, the incident was immediately reported and investigated, as identified by their policy.	F 226		
F 244 SS=E	483.10(f)(5)(iv)(A)(B) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION (f)(5) The resident has a right to organize and participate in resident groups in the facility. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to address a resident council request to have the administrator or DON present during council meetings, which had the potential to affect 6 of 6 residents (R13, R65, R6, R53, R48 and R30) who attended council meetings. Findings include: R13's quarterly Minimum Data Set (MDS) dated 9/11/16, identified intact cognition. The MDS also	F 244	F224- Listen to Group Grievances Talahi Nursing and Rehab Center does consider the views of the resident council and does act promptly upon the request of resident council. The DON and Dietary Director attended the November make up council meeting on 12/9/6 to address any questions or concerns that council might have.	1/17/17

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F 244	Continued From page 13 indicated R13 was usually understood when expressing ideas and could make her needs known. R65's quarterly MDS dated 11/19/16, indicated cognitive impairment. The MDS also indicated R65 was understood when expressing ideas and could make her needs known. R6's quarterly MDS dated 10/25/16, indicated intact cognition. The MDS also indicated R6 was understood when expressing ideas and could make his needs known. R53's quarterly MDS dated 9/6/12, indicated moderate cognition impairment. The MDS also indicated R53 was usually understood when expressing ideas and could make her needs known. R48's quarterly MDS dated 11/19/16, indicated cognitive impairment. The MDS also indicated R48 was understood when expressing ideas and could make her needs known. R30's quarterly MDS dated 9/3/16 indicated intact cognition. The MDS also indicated R30 was understood when expressing ideas and could make her needs known. During interview on 12/6/16, at 3:23 p.m. R13 stated she attended the resident council meetings. During the September meeting, there was a suggestion made to have the administrator or the DON (director of nursing) present at the meetings. R13 stated it was "frustrating" not having management there, and would be nice just to have their presence. R13 stated she would	F 244	The DON and Administrator attended the December regular council meeting on 12/16/16 to address any questions or concerns the council might have. There were no concerns at that time. R65 and R6 were in attendance at both meetings. R53, R48, and R30 are not identified on the state supplied stage 2 sample resident list. The Administrator and the DON were re-educated by Regional Director of Operation on, but not limited to the necessity to listen and follow through on group and individual grievances. An audit tool was created to ensure proper follow through after each monthly resident council meeting. this tool will be reviewed by each QA meeting. The DON, Administrator, Dietary Director, Activity Director, Maintenance Director and Social Service will be available to attend each resident council meeting as requested. Social Service is responsible	

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F 244	Continued From page 14	F 244		

like them partake in the meeting process, and added they wouldn't have to stay the whole time. R13 stated it would be nice "just to hear us guys out." R13 could not recall seeing the DON or the administrator present at either the September or October resident council meeting.

Resident council meeting minutes from June, July, August, September and October 2016 were reviewed. The minutes dated Friday September 16, 2016 indicated under new business, "Residents expressed that they would like to have the administrator, director of nursing and possibly dietary attend meetings on a periodic basis in order for them to hear concerns and give suggestions for improvement or change."

A review of the council meeting minutes dated October 21, 2016, indicated the residents 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

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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 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 also stated it would not be difficult for either the administrator, the DON, or other staff to be at the meetings. Further, SW stated at the next resident council meeting, administration should be present to discuss how often they should come. The SW stated there were no resident council meetings held in November.

During interview on 12/7/16, at 3:57 p.m., the director of nursing (DON) stated she was not informed of the council's request, nor received the council meeting minutes to read about their request. The DON thought she had to be "invited" to the council meeting. Further,the DON stated she is always talking with residents on the units, on a daily basis, and that this would be another way for residents, and staff, to talk about what their needs are.

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F 244	Continued From page 16 A facility policy, "Resident Council", revised 5/23/2014, indicated its objective "...to promote a sense of belonging and community decision making among the residents," and would "...provide residents with the opportunity to air any grievances that hey may have and to give suggestion on what they would like." The policy further indicated grievances aided during the meeting should be "addressed within the proper department," and that any follow-up can be addressed "at the next Resident Council Meeting."	F 244		
F 250 SS=D	483.40(d) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE (d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the necessary social services to assist residents in finding a physician for 1 of 1 residents (R31) who did not have a primary physician. Findings include: R31's admission minimum data set (MDS), dated 8/26/16, indicated no cognitive impairment. R31's hospital discharge report, dated 8/19/16, indicated she had been admitted to the facility following a hospital stay related to leg pain, which also indicated a follow up appointment with her primary physician at the facility in one week. R31's diagnosis list, dated 12/7/16, further	F 250	F250 Provision of Medically related Social Service Talahi Nursing and Rehab Center does provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. R31 has an established physician and is followed on a regular basis by the physician. Social Service has been re-educated on their role in assisting residents to establish a primary care physician.	1/17/17

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 17 identified an admission diagnosis of cellulitis (skin infection) along with a history of diabetes with nephropathy (kidney damage), heart failure, and chronic obstructive pulmonary disease. Review of physician and physician assistant (PA) notes identified the following: On 8/31/16, R31 received a visit and was assessed by her primary medical doctor (MD-B). The note indicated that R31 needed monthly visits due to her "Advanced multiple comorbid conditions with multiple medications" and that "Given long-term placement in skilled nursing facility will need to transfer care." On 10/17/16, 47 days after her last physician visit, R31 had an appointment to establish care with a different physician, MD-C outside the facility who assessed R31. The note identified MD-C would be contacting the facility to "Clarify the issue concerning R31's non-eligibility for in-facility care." On 10/24/16, MD-C declined to take R31 as a patient recommending an Internal Medicine Provider, and offered to place referral for the facility. On 11/3/16, 76 days after her admission, R31 had an appointment with a PA-A. After assessing R31, the PA-A also declined to take R31 as a patient due to her complex medical history and recommended an Internal Medicine Physician. On 11/18/16, 91 days after she was admitted, R31 had an appointment with a MD-D outside the facility who completed an assessment of R31 and became her primary physician. R31's medical record lacked any indication social	F 250	Health Unit Coordinator maintains an audit to track date of admission and dates for required re-visits for all new admissions. Social Services reviews audit tracker weekly to assure compliance. An audit of all residents has been completed to assure physician visits are compliant. QAPI will review this audit and make recommendations on it's continuance. Social Service, Admissions Coordinator, Health Unit Coordinator, DON are responsible.	

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F 250	Continued From page 18 services was involved in assisting R31 to establish care with a primary physician while a resident at the nursing the facility. During interview on 12/7/16, at 5:29 p.m. medical director (MD)-A stated he was unaware R31 was not assessed by a physician in September or that she had subsequently been denied care twice. MD-A stated it was the responsibility of R31's primary physician to continue care until a replacement physician was found. However, after R31 was denied care from her primary physician, he would have expected the facility's social services to aide in finding R31 an appropriate physician. During interview on 12/8/16, at 11:03 a.m. social worker (SW)-A stated residents were typically followed by their primary physician, unlike R31's situation. SW-A stated she thought the nursing staff were working on finding R31 a new physician and social services did not have any role in assisting R31 to find a physician.	F 250		
F 257 SS=B	483.10(i)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS (i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81 degrees F. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide housekeeping and maintenance services necessary to maintain comfortable temperatures 2 of 5 resident rooms (R162, R165) and one or three resident dayrooms reviewed in the facility, which had the	F 257	F257- Comfortable Temperatures Talahi Nursing and Rehab Center does maintain safe temperature levels. The windows were closed in R162 and	1/17/17

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F 257	Continued From page 19 potential to affect 50 residents who used these areas. Findings include: During observation on 12/08/16, at 12:47 p.m. an environmental tour of the facility was conducted with maintenance supervisor (MS) who confirmed the following findings: The resident dayroom, located off of the main dining room, was cool. The temperature measured at 66 degrees Fahrenheit (F). In R162, the temperature in the room measured at 70 degrees F. In R167 the temperature in the room measured at 66 degrees F. On 12/08/16, at 1:03 p.m. MS confirmed all of the findings listed above. MS stated the usual facility practice was for facility staff to notify maintenance with concerns with paper slips, which were picked up in the morning and as needed by the maintenance staff. Further, MS stated he had not checked resident or common area room temperatures in over a month because he did not "have time," and was working on getting around to it. A policy on facility maintenance was requested, but was not provided during the survey.	F 257	R165 to prevent cooling of these areas. Maintenance was in-serviced to ensure proper temperatures are maintained. Maintenance will conduct audits in three random locations five times weekly for a period of three weeks, and make adjustments as indicated for temperatures outside the parameter of 71-81 degrees F. Audits will continue weekly for one more month after this period. QAPI will review audits for compliance at regularly scheduled meetings and make recommendations for continuance. Maintenance will be responsible.	
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development	F 280		1/17/17

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F 280	Continued From page 20	F 280		

and implementation of his or her person-centered plan of care, including but not limited to:

(i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.

(ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.

(iv) The right to receive the services and/or items included in the plan of care.

(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.

(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--

(i) Facilitate the inclusion of the resident and/or resident representative.

(ii) Include an assessment of the resident’s strengths and needs.

(iii) Incorporate the resident’s personal and cultural preferences in developing goals of care.

483.21
(b) Comprehensive Care Plans

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F 280	Continued From page 21 (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to update the resident	F 280	F280-Right to Participate in Planning Care Plans	

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F 280	Continued From page 22 plan of care for falls with new interventions after a reassessment was completed for 1 of 2 residents (R92) reviewed for falls. Findings include: R92's diagnoses, as identified on the face sheet dated 12/8/16, included chronic respiratory failure, anxiety disorder and weakness. R92's admission Minimum Data Set (MDS) dated 11/22/16 indicated moderately impaired cognition. The care area assessment (CAA) for falls dated 11/22/16 identified R92 was at risk for falls due to shortness of breath with activity, unsteady gait and balance. The CAA also indicated R92 was working with therapy for strengthening and endurance, was making progress, and staff were to assist with mobility and transfers. During observation on 12/06/16 at 2:22 p.m., R92 was seated in her wheel chair just outside her room door. R92 wore shoes and socks, had oxygen tubing to the right of the wheel chair, with a nasal cannula in place. Clipped to her shirt was a cord, which lead directly to a TABS (a personal, movement-detecting safety) alarm, fastened to the back of the wheel chair. Review of an Investigation Report dated 11/22/16 indicated R92 had an unwitnessed fall in her room on 11/20/16. The interdisciplinary team added an intervention to place a TABS (a personal, movement-detecting safety) alarm for R92 when in wheel chair or in bed. The care plan, revised 11/21/16, identified R92 was at high risk for falls, and directed staff to: anticipate and meet resident's needs; be sure the call light is within reach and encourage to use;	F 280	It is the policy of Talahi Nursing and Rehab Cento to establish a care plan for all residents which accurately reflects their needs and strengths and guides staff in providing resident care. The policy has been reviewed and is current. R92 does not have a TABS alarm. The care plan, and nurse Aide care sheets are accurate. Education was completed for direct care staff on following the care plan. All care plans are reviewed in conjunction with the RAI process. Audits of care provided, per the developed care plan, will be conducted on five random residents weekly for two months. QAPI will review audits for compliance at regularly scheduled meetings and make recommendations for continuance. DON or designee is responsible	

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F 280	Continued From page 23 encourage resident to participate in activities that promote exercise for strengthening; ensure resident is wearing appropriate footwear; follow fall protocol; and PT (physical therapy) evaluate and treat. R92's care plan lacked the TABS alarm intervention. Review of the nursing aide care sheets, undated, identified R92 required stand by assist, was a moderate fall risk, was to bet toiled every 2 hours, and had a regular diet. The sheet did not include R92's fall intervention to use the TABS alarm. During an interview on 12/8/16 at 10:02 a.m., nursing assistant (NA)-I stated she always carried and used her nursing sheet. After reviewing the sheet, NA-I said there was nothing about R92's alarm, "but I know [R92] is supposed to have the alarm on." NA-I stated she learns of changes to residents care plans at the change of shift meetings, but it would be important to know the care plan, especially 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 care plan in the resident's chart should have been updated, as well as the aide cares sheets. The DON stated the unit managers were responsible, and it was a matter of getting that task "completed and updated." 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.	F 280		

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F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a care plan, sufficient to meet the needs of a newly admitted resident for 1 of 1 newly admitted residents (R94) identified at risk for pressure ulcers and skin breakdown. Findings include: R94's Admission Record, undated, indicated she had dementia and neurological disorder. The Admission Record indicated R94 was admitted to the facility on 12/01/16, and the Minimum Data Set had not been completed. A Braden Skin assessment, dated 12/01/16, indicated R94 had occasionally moist skin, was bed fast, had very limited mobility and had potential problem with friction and shear. The assessment resulted a score of 14, which indicated R94 was at moderate risk for developing a pressure ulcer. R94's Individual Resident Care Plan (a temporary care plan) dated 12/1/16, indicated she was incontinent of bowel and bladder and was toileted on rounds. The temporary care plan did not indicate or identify R94 was at risk for pressure ulcers, so interventions could be implemented to	F 281	F281- Services Provided to Meet Professional Needs It is the policy of Talahi Nursing and Rehab Center to establish a temporary care plan within 24 hours of admission. R94 initial temporary care plan was establish on admission. This care plan was reviewed for ADL's toileting needs and repositioning needs and is current and accurate. All care plans are reviewed in conjunction with RAI process. Education completed to all direct care staff on following the care plan and implementing accurate and timely care plans. All temporary care plans have been reviewed to ensure that they meet the residents needs. Audits of care provided, per the developed care plan, will be conducted on five random residents weekly for two months.	1/17/17

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F 281	Continued From page 25 reduce R94 risk for developing pressure ulcers. During observation and interview 12/07/16, at 8:18 a.m., NA-E stated he was checking on R94, and that she was supposed to have two staff to provide cares. NA-E stated he was going to find someone to help him. NA-E returned alone at 8:30 a.m., and said he was unable to find help. At 8:34 a.m. NA-E removed R94's incontinence pad that was moderately soaked with urine, and was incontinent of a small bowel movement. R94's entire peri- area was red and excoriated (damage or remove part of the surface of the skin). NA-E stated R94's bottom was very red, and applied peri cream to the area. NA-E then stated he started at 6:00 a.m. and this was the first time during his shift he had provided cares to R94. NA-E said he did not know when R94 was last changed. During interview 12/07/16, at 1:10 p.m., registered nurse (RN)-C stated R94 should be repositioned every two hours because "she is at risk" for skin breakdown. RN-C then stated this should have been on R94's care plan. 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 need and strengths, and guides staff in providing resident care." The policy further indicated with in 24 hours of admission, a temporary care plan will be initiated which will accurately reflect resident needs and strengths, and guides staff in providing resident care.	F 281	Audit of all temporary care plans to assure the temporary care plan meets the residents needs will be conducted for two months. Repositioning and toileting audits will be conducted on five random residents weekly for the next two months. QAPI committee will review all audits for compliance at regularly scheduled meetings and make recommendations for continuance. DON or designee is responsible	
F 282 SS=E	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282		1/17/17

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F 282	Continued From page 26 (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the plan of care was implemented for 4 of 5 residents (R41, R49, R94 and R87) reviewed who were dependent on staff for activities of daily living (ADLs). Findings include: BATHING R41's quarterly Minimum Data Set (MDS) dated 11/21/16, identified R41 was moderately cognitively impaired and required total assistance from facility staff for activities of daily living (ADL)'s. In addition, R41 had no rejection of ADL's during the MDS assessment period. R41's plan of care, dated 10/06/16, noted R41 had an identified problem for ADL self-care deficit related to her (R41's) dementia. Further, the care plan identified R41 required extensive assistance of 1 with ADL's and was to receive a tub bath once a week as requested by R41. In addition, the care plan noted R41 was to be provided a sponge bath, when a full bath could not be tolerated. During an interview with R41 on 12/05/16, at	F 282	F282- Services Provided by Qualified Persons per Care Plan It is the policy of Talahi Nursing and Rehab Center to ensure the plan of care is followed for all residents. This policy has been reviewed and is current. R41 care plan has been reviewed and updated to reflect current receiving bed bathing needs. The nurse Aide Care Sheet is accurate. Staff re-educated on R41 bathing and documentation. A recumbent shower chair has been ordered to accommodate a full shower for R41 , and other residents as the need arises. The care plan for R49 was reviewed for dietary needs. Nurse Aide Care Sheet is accurate. R94 care plan has been reviewed and	

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F 282	Continued From page 27 12:41 p.m. R41 stated she had not received weekly scheduled bath on a "regular basis " and was concerned because she required assistance from facility staff with her ADL's. R41's Body Audit Form identified R41 had 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 indication that R41 had rejected ADL's with bathing 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, but was a "tough one" to bathe. 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 according to her care plan. Further RN-D stated R41's baths,"were not happening "according to the body audit forms. During interview on 12/07/16, at 11:26 a.m. with director of nursing (DON) stated she was aware residents in the facility were not receiving their baths as directed by the care plan. ASSISIT DEVICES R49's quarterly MDS dated 10/15/16, indicated R49 was severely cognitively impaired needed supervision and set up with eating. R49's care plan dated 08/10/16, indicated, "This resident requires mechanical soft diet and cueing	F 282	updated to reflect current turning, toileting and repositioning needs. The nurse aide care sheet has been updated. Staff have been re-educated on R94 turning, toileting and repositioning needs. The care plan of R87 was reviewed and updated to include direction to staff for positioning and nurse aide sheet is accurate. Staff were re-educated on following the care plan. Audits of care provided, per the developed care plan, will be conducted on five random residents weekly for two months. QAPI committee will review all audits for compliance at regularly scheduled meetings and make recommendations for continuance. DON/designee is responsible.	

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F 282	Continued From page 28	F 282		

by staff to eat. Cut up food as needed, coffee- fill cup half full and cool with ice prior to placing at the table, coffee should be luke warm."

During observation 12/07/2016, at 12:34 p.m. nursing assistant (NA)-G provided R49 her lunch tray along with a cup of coffee 3/4 full. There was no ice in the coffee and visible steam was coming from the cup.

During interview 12/07/16, at 12:40 p.m. NA-G stated she was not aware of any interventions they provide to keep her coffee luke warm.

Review of Incident report dated 7/27/16 at 8:30 a.m., indicated R49 was given coffee prior to breakfast meal and R49 spilled coffee on her lap. Immediate interventions included: fill coffee/hot liquid half full, and add ice cubes to cool to room temperature; and signage placed by coffee carafe in east kitchen to remind of new intervention.

Although R49 received a injury from hot coffee care planned interventions were not followed to prevent an additional injury.

During interview 12/07/16, at 2:22 p.m. registered nurse (RN)-B stated she thought R49's coffee should be luke warm by adding water, and after looking at her care plan it should have ice placed in it.

INCONTINENCE
R94's Admission Record undated indicated she had dementia and neurological disease. A facility Continence Evaluation form dated 12/06/16, indicated she was incontinent of bladder, onset was unknown, unable to sit on the toileted and

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 29 was not motivated to toilet. R94's Individual Resident Care Plan (temporary care plan) dated 12/1/16, indicated she was incontinent of bowel and bladder and toilet on rounds (every two hours). The care plan indicated R94 was high risk for falls, was unable to reposition herself. R94's nursing assistant care sheet, undated, instructed staff to toilet the resident every two hours. During continuous observation on 12/07/16, from 6:00 a.m. to 8:34 a.m. (2 hours and 34 minutes) R94 was lying in her bed on her right side with her nightgown on. There was no staff for R94 observed during this time. A 7:52 a.m. nursing assistant (NA)-E looked into R94's room and walked by. At 8:13 a.m. NA-E entered R94's room stated he was checking on R94, but did not provide R94 with any cares. At 8:34 a.m. NA-E re-entered the room and removed R94's pad which was moderately soaked with urine, and had a small bowel movement. R94's entire peri- area was red and excoriated (damage or remove part of the surface of the skin). NA-E stated her bottom was very red, and applied peri cream to the area. NA-E stated he started at 6:00 a.m. and this was the first time during his shift he had provided cares to R94. NA-E said he did not know when R94 was last changed. During interview 12/07/16, at 1:10 p.m. registered nurse (RN)-C stated R94 was incontinent of urine and should be toileted every two hours according to her care plan.	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245438	A. BUILDING ______ B. WING ______	C 12/08/2016

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

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F 282	Continued From page 30 FALL INTERVENTIONS R87's admission Minimum Data Set (MDS), dated 10/4/16, identified R87 was mildly, cognitively impaired, used a wheelchair for locomotion, and was at risk for falls and dependent upon staff for activities of daily living. R87's care plan, dated 11/8/16 identified R87 at high risk for falls and included interventions for "Dycem non-slip material to remain in wheelchair at all times while resident is up in chair." R87's care plan did not direct staff to fasten the wedge cushion to the wheelchair. 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 the evening meal at 4:48 p.m., R87 was again observed seated in his wheelchair, and no Dye was present in the wheelchair. During observation on 12/8/16, at 9:09 a.m. R87 was seated in his wheelchair during breakfast, and no Dycem was observed in R87's wheelchair. During interview on 12/8/16, at 9:16 a.m. nursing assistant (NA)-F stated R87 did not have any Dycem in his wheelchair. NA-F stated she was unaware of dycem being a fall intervention, or was needed in R87's wheel chair. During interview on 12/8/16 at 11:13 a.m., the director of nursing (DON) stated fall interventions were communicated to staff daily at morning meetings. The DON further stated staff were expected to remember the interventions, and be implementing them. A policy regarding implementation of resident care plans was requested, but not provided.	F 282		

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F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide baths and timely toileting assistance for 2 of 3 residents (R41, R94) reviewed that were dependent upon staff for activities of daily living (ADLs). Findings include: R41's quarterly Minimum Data Set (MDS) dated 11/21/16, identified R41 was moderately cognitively impaired and required total assistance for ADL's. In addition, R41 had no rejection of ADL's during the MDS assessment period. R41's plan of care dated 10/06/16, noted R41 had an identified problem for ADL self-care deficit related to her (R41's) dementia. Further, the care plan identified R41 required an extensive assistance of one with ADL's and was to receive a tub bath once a week as requested by R41. In addition, the care plan noted R41 was to be provided a sponge bath when a full bath could not be tolerated. During an interview with R41 on 12/05/16, at 12:41 p.m. R41 stated she had not received weekly scheduled baths on a "regular basis "and was concerned because she required assistance from facility staff for her ADL's. R41's Body Audit Form identified R41 had	F 312	312-ADL Care Provided For Dependent Residents. Talahi Nursing and Rehab Center does provide residents whom are unable to carry out activities of daily living with services to maintain personal hygiene, and timely toileting assistance. R41 and R49 were assessed for and care plans reviewed for bathing and toileting needs. Education was provided to staff on following the care plan and providing care according to the care plan. Education was provided on completion of bathing sheets. Audits of care provided, per the developed care plan, will be conducted on five random residents weekly for two months. QAPI committee will review all audits for compliance at regularly scheduled meetings and make recommendations for continuance. DON/designee is responsible	1/17/17

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F 312	Continued From page 32	F 312		

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 bowel and bladder and was toileted on rounds.

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F 312	Continued From page 33 An untitled and undated nursing assistant care sheet, identified R94 was to be toileted every two hours. A Continence Evaluation assessment dated 12/06/16, indicated R94 was incontinent of bladder and wore a brief. The assessment further indicted it was unknown if R94 had an urge to void and did not use the toilet. During continuous observation on 12/07/16, from 6:00 a.m. to 8:34 a.m. (2 hours and 34 minutes) R94 was lying in her bed on her right side with her nightgown on. There was no staff for R94 observed during this time. A 7:52 a.m. nursing assistant (NA)-E looked into R94's room and walked by. At 8:13 a.m. NA-E entered R94's room stated he was checking on R94, but did not provide R94 any cares. At 8:34 a.m. NA-E re-entered the room and removed R94's pad which was moderately soaked with urine, and had a small bowel movement. R94's entire peri- area was red and excoriated (damage or remove part of the surface of the skin). NA-E stated her bottom was very red, and applied peri cream to the area. NA-E stated he started at 6:00 a.m. and this was the first time during his shift he had provided cares to R94. NA-E said he did not know when R94 was last changed. During interview 12/07/16, at 1:10 p.m. RN-C stated R94 was incontinent of urine. RN-C reported (R94) was dependent upon staff and at risk for skin breakdown, and should be checked and changed every two hours.	F 312		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314		1/17/17

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F 314

Continued From page 34

(b) Skin Integrity -

(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-

(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and

(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review the facility failed to provide timely assistance for toileting and repositioning to reduce the risk of pressure ulcer development for 1 of 3 residents (R94) identified at risk of pressure ulcers.

Findings include:

R94's undated Admission Record indicated R94 was admitted on 12/01/16, which included diagnoses of dementia and multiple sclerosis (A disease in which the immune system eats away at the protective covering of nerves). R94's admission Minimum Data Set (MDS) was not completed.

A Braden Skin assessment (scale for predicting pressure ulcer risk) dated 12/01/16, indicated R94 had occasionally moist skin, was bed fast,

F 314

F314- Treatment to Prevent Pressure Sores

Talahi Nursing and Rehab Center does provide care consistent with professional standards of practice to prevent pressure ulcers.

R94 was comprehensively re-assessed for skin risk.

R94 care plan was reviewed and is current.

All residents identified as at risk for pressure ulcer development have been reviewed to assure accuracy and to ensure they are receiving appropriate care.

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F 314	Continued From page 35 had very limited mobility, with a potential problem of friction and shear. The assessment had a score of 14 which indicated R94 was at moderate risk for developing a pressure ulcer. R94's Individual Resident Care Plan (temporary care plan) dated 12/1/16, indicated R94 was incontinent of bowel and bladder and was to be toileted on rounds. R94's care plan did not indicate she was at risk for pressure ulcers. During continuous observation on 12/07/16, from 6:00 a.m. to 8:34 a.m. (2 hours and 34 minutes) R94 was lying in her bed on her right side with her nightgown on. There was no staff for R94 observed during this time. At 7:52 a.m. nursing assistant (NA)-E looked into R94's room and walked by. At 8:13 a.m. NA-E entered R94's room and said he was checking on R94, but did not provide R94 any cares. At 8:34 a.m. NA-E re-entered the room and removed R94's pad which was moderately soaked with urine, and had a small bowel movement. R94's entire peri- area was red and excoriated (damage or remove part of the surface of the skin). NA-E stated her bottom was very red, and applied peri cream to the area. NA-E stated he started at 6:00 a.m. and this was the first time during his shift he had provided cares to R94. NA-E said he did not know when R94 was last changed. During interview 12/07/16, at 1:10 p.m. registered nurse (RN)-C stated R94 was incontinent of urine, and at risk for skin breakdown. She should be checked/changed every two hours and repositioned during this time. A facility policy "Prevention and Treatment of Skin Breakdown." reviewed 3/2016, directed staff to	F 314	The policy for prevention and treatment of pressure ulcers/skin breakdown was reviewed and is current. The policy for evaluation of skin risk was reviewed and is current. Education was provided to clinical staff on the policy and procedure for prevention of pressure ulcers/skin breakdown. Audits of care provided, per developed care plan, will be conducted on five random residents weekly for two months. After which the IDT will review and make further recommendations. QAPI committee will review all audits for compliance at regularly scheduled meetings and make recommendations for continuance. DON/designee is responsible	

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F 314	Continued From page 36 "Properly identify and assess residents who's clinical conditions increase the risk for impaired skin integrity, and pressure ulcers, to implement preventative measures, and to provide appropriate treatment modalities for wounds according standards of care."	F 314		
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.	F 315		1/17/17

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F 315	Continued From page 37 (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on 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 Findings include: R38's admission Minimum Data Set (MDS) dated 08/04/16, indicated R38 was always continent of urine. The quarterly MDS dated 10/31/16, indicated R38 was frequently incontinent of urine (7 or more episodes of incontinence but at least one episode of continence). The care area assessment (CAA) dated 8/10/16, identified R38 was on a diuretic (reduces fluid), and needed assistance with toileting. Further, the CAA identified R38 did not always ask for assistance due to cognitive impairment, and staff were to toilet R38 every two hours. R38's care plan dated 08/09/16, indicated he required extensive assistance of one for toileting. A Bladder 7 Day Documentation from 7/28/16 thru 8/4/16, indicated R38 was never incontinent of urine. A subsequent bladder assessment from 10/26/16 thru 11/1/16, indicated R38 was incontinent of urine nine times, which was a change in status from his previous assessment in August 2016.	F 315	F315-No catheter, Prevent UTI, Restore Bladder Talahi Nursing and Rehab Center provides appropriate treatment and services to residents to restore continence to the extent possible. The assessment tool for evaluating urinary continence has been reviewed and is current. R38 has completed a seven day reassessment for bladder continence, and the care plan and care assessment sheet have been updated to reflect the current status. Residents identified as incontinent were reviewed to ensure they are receiving accurate assessments, and appropriate services as indicated by those assessments. The bowel and bladder assessment policy and procedure has been reviewed and is current. Staff have been re-educated to the bowel and bladder assessment policy and procedure.	

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F 315	Continued From page 38 The quarterly bladder assessment dated 11/1/16 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 pad and 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. 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 possible.	F 315	The facility will complete three audits per week for three weeks on bowel and bladder assessments, and appropriate treatments and services indicated by those assessments. QAPI committee will review all audits for compliance at regularly scheduled meetings and make recommendations for continuance. DON/designee is responsible	

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F 323	Continued From page 39	F 323		
F 323 SS=E	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate supervision and interventions were implemented to prevent accident hazards for 4 of 5 residents (R87, R49, R75, R37) reviewed for accidents. In addition, the facility failed to ensure bed rails were properly fastened and secured to the bed frame to promote safety for 1 of 20 residents (R3) who had loose bed rails.	F 323	F323 Free of Accidents Talahi Nursing and Rehab Center assures each resident receives adequate supervision to prevent accidents. R87 care plan was reviewed and is current.	1/17/17

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F 323	Continued From page 40	F 323		

Findings include:

FALLS
R87's admission Minimum Data Set (MDS), dated 10/4/16, identified R87 was cognitively impaired, used a wheelchair for locomotion, and was at risk for falls.

R87's admission Care Area Assessment (CAA), dated 10/10/16, identified R87 was at risk for falls 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 recieved 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 the evening meal at 4:48 p.m., R87 was again observed seated in his wheelchair, and no

Fall prevention policy was reviewed and is current.

R49 care plan was reviewed and is current.

R75 care plan was reviewed and is current.

R3 side rails were secured at time of survey, and maintenance checks these retails daily to assure they are secure.

Staff were re-educated on appropriate interventions to reduce the risk of resident to resident altercations, falls and following the care plan to prevent accidents.

Maintenance performs three random audits weekly for three weeks to assure side rails are secure.

All beds with rails have been checked to ensure they are tightly secured.

Dietary conducts three audits weekly for three weeks to assure dietary guidelines are being followed.

QAPI committee will review all audits for compliance at regularly scheduled meetings and make recommendations for continuance.

DON/designee, Maintenance Director, Dietary Director are responsible.

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 41 dycem was present in the wheelchair. During observation on 12/8/16, at 9:09 a.m. R87 was seated in his wheelchair during breakfast, and no dycem was observed in R87's wheelchair. During interview 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., registered nurse (RN)-C stated R87 no longer needed the dycem in his wheelchair once R87 recieved the new wheelchair cushion, which provided a non slip surface. RN-C stated the care plan had not been revised to discontinue the dycem. During interview on 12/8/16, at 10:02 a.m. occupational therapist (OT)-A stated R87 needed the dycem in his wheelchair, and his wheelchair cushion did not provide an appropriate non slip surface. During interview on 12/8/16 at 11:13 a.m., the director of nursing (DON) stated fall interventions were communicated to staff daily at morning meetings. The DON further stated staff were expected to remember the interventions, and be implementing them. A facility policy titled "Fall Prevention," dated 9/1/16, directed all new admissions to the facility would be assessed for fall risk. The fall interventions on the care plan and assessment were to be implemented. COFFEE BURN	F 323		

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F 323	Continued From page 42 R49's quarterly MDS dated 10/15/16, indicated R49 was severely cognitively impaired, and needed supervision and set up with eating. A Progress Note dated 7/27/16, at 11:34 a.m. indicated R49 had picked up the coffee cup, was moving cup to her mouth spilled the hot coffee on left arm and lap. Reddened area appeared on left arm approximately "5' (inches) by 2", lap was reddened area on left leg 8" by 4", right leg 7" by 3". A Risk Management report dated 7/27/16, indicated "Client was sitting at table in dinning room for breakfast. Client was given beverages prior to getting meal. While client was waiting for breakfast client grabbed the cup, moved it toward her mouth and accidentally spilled her coffee on her left arm and lap." Writer placed intervention in place for staff to fill coffee/hot liquid containers half full and add ice cubes to cool to room temp prior to serving, signage placed in front of the coffee carafes in east kitchen to remind staff of intervention. R49's care plan dated 08/10/16, indicated "This resident required a mechanical soft diet and cueing by staff to eat. Cut up food as needed, coffee fill cup half-full and cool with ice prior to placing at the table, coffee should be luke-warm." During observation 12/07/2016, at 12:34 p.m., nursing assistant (NA)-G provided R49 with her lunch tray along with a cup of coffee 3/4 full. There was no ice in the coffee, and steam was observed coming from the top of the coffee cup. During interview on 12/07/16, at 12:40 p.m. NA-G stated she was not aware of any interventions	F 323		

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F 323	Continued From page 43 they provide to keep R49's coffee luke warm. During interview on 12/07/16, at 2:22 p.m., registered nurse (RN)-B stated R49's coffee should be luke warm by adding water. RN-B then stated R49's care plan indicated ice should be placed in her cup to keep it luke warm, not water. RN-B thought that intervention for R49 had changed. RESIDENT TO RESIDENT ALTERCATION R75's quarterly Minimum Data Set (MDS) dated 11/5/16, indicated she was severely cognitively impaired and depressed. R75's care plan dated 09/29/16, indicated she had a behavior of repeatedly asking for certain staff, related to dementia with behavior disturbance. The care plan directed staff to assist R75 to develop more appropriate methods of coping and interacting, and to encourage R75 to express feelings appropriately. R37's quarterly MDS dated 11/1/16, indicated she was severely, cognitively impaired and had diagnoses which included dementia. A progress note dated 10/12/16 at 3:58 p.m. indicated R75 was observed to hover over another resident (R37). The note indicated staff instructed R75 to stay away from the other resident's personal space, because R37 was agitated. R75 walked over and gave R37 a left sided upper body hug. R37 swung their right fist and hit R75 in the head. There were no apparent injuries. R75 was again advised to go to her room if she couldn't keep to herself. R75 did go to her	F 323		

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F 323	Continued From page 44	F 323		

room and no further behaviors were identified.

An Incident Report dated 10/13/16, indicated that on 10/12/16, in the afternoon staff had noted R75 standing near R37, showing concern for her. Staff offered R75 reassurance and asked her to give R37 some personal space as R37 displayed some agitation towards others at this time. R37 was in Broda chair (tilting and reclining wheelchair) and R75 was ambulating using her walker. She preceded to walk up to R37 and gave her a left sided hug. R37 then proceeded to make a fist with her right hand and strike R75.

Although staff offered reassurance to R75 before the altercation with R37. There was no change with interventions implemented for either resident, after R37 struck R75, to help reduce the risk of resident to resident altercations and keep both residents safe.

LOOSE SIDE RAILS
R3's quarterly Minimum Data Set (MDS) dated 8/11/16 identified R3 was cognitively intact and required extensive assistance with activities of daily living (ADL's). R3 had a diagnosis of severe morbid obesity and generalized muscle weakness.

During observation on 12/05/16, at 3:10 p.m R3's bed was fittend with bilateral, quarter side rails, approximately 24" (inches) in length and 8" in height. The rails were fastened to bed frame, with a screw. When grasped, each rail could be moved back and forth approximately 2" from the bed frame.

During interview on 12/05/16, at 3:19 p.m. with registered nurse (RN)-E stated (R3's) side rails

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F 323	Continued From page 45 felt "very loose" and was a safety risk for R3. Further, RN-E stated R3 frequently used the side rails to assist her in sitting up in bed. When interviewed on 12/05/16, at 3:22 p.m. R3 stated the side rails had always been "very loose" and were difficult to use when they were that loose. During interview on 12/05/16, at 6:53 p.m. the registered nurse (RN)-A stated R3's side rails felt "wobbly" which placed the resident at risk for falls and may become an entrapment risk if the side rails became any looser. On 12/08/16, at 1:03 p.m. MS stated the usual facility practice was for facility staff to notify maintenance with concerns with paper slips. Further, MS stated there was no system in place for side rail maintenance. Review of policy titled, "Side Rails" dated 6/11/16 identified staff members are to assess the side rail is safe, provide education to residents and are utilized within manufacture's instructions.	F 323		
F 329 SS=D	483.45(d) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS (d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or	F 329		1/17/17

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F 329	Continued From page 46 (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure non-pharmacological interventions and behavior monitoring were completed prior to administering anti-anxiety medications for 1 of 5 residents (R80) reviewed for unnecessary medications. Findings include: R80's quarterly Minimum Data Set (MDS) dated 08/11/16, indicated R80 had no cognitive impairment with a diagnosis of major depressive and anxiety disorder. R80's Care Area Assessment (CAA) dated 11/15/16, noted R80 had no behaviors or psychosis and required extensive assistance of one with activities of daily living (ADL's). R80's care plan dated 02/23/16, indicated R80 had an identified problem of, "Resident uses anti-anxiety medications [Ativan] related to anxiety disorder." Interventions for R80 included; monitor/record occurrence for behaviors symptoms and document per facility protocol. There was no indication of how R80's exhibited her anxiety.	F 329	F329 Drug Regimen is Free from Unnecessary Drugs Talahi Nursing and Rehab Center does ensure that residents are free from unnecessary dru7ggs without adequate indications. R80 care plan was updated to include signs and symptoms of anxiety and non-pharmacological approaches to attempt prior to administration of lorazepam. The psychotropic medications use guideline policy was reviewed and updated. All residents who receive PRN psychotropic medications were reviewed to ensure non-pharmaceutical interventions are in place and attempted prior to medication administration. Audit to ensure non-pharmaceutical interventions are trialed prior to medication administration up to five	

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F 329	Continued From page 47 During observation on 12/6/16 between 1:45 p.m. to 2:28 p.m. R80 exhibited no outward signs of anxiety. During observation on 12/7/16 from 6:00 a.m. to 8:30 a.m., R80 presented no signs of anxiety. 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. In September 2016, R80 took her as needed lorazepam on 10 different occasions. During the above episodes no signs of anxiety, or non-pharmacological interventions were attempted prior to the use of the medication. In October 2016, R80 received 7 doses of lorazepam, and signs of anxiety, or non-pharmacological interventions were attempted prior to the use of the medication. There was no indication of why the medication was being given. In November 2016, R80 took 6 doses of lorazepam and signs of anxiety, or	F 329	random residents per week for two months who receive PRN psychotropic medications. All staff have been re-educated to non-pharmacological interventions prior to administration of anti-anxiety medications. QAPI committee will review all audits for compliance at regularly scheduled meetings and make recommendations for continuance. DON/designee is responsible.	

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F 329	Continued From page 48 non-pharmacological interventions were attempted prior to the administration of the medication. Review of R80's pharmacist drug regimen review on 01/20/16, the consultant pharmacist (CP) indicated facility staff needed to document behaviors, non-pharmacological approaches attempted and effectiveness for R80's as needed lorazepam. On 11/14/16, the CP again indicated the documentation on R80's lorazepam needed to include behaviors and non-pharmacological interventions. 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. When interviewed on 12/07/16, the director of nursing (DON) stated it was important for facility staff to document non-pharmacological interventions and behaviors "to evaluate" the effectiveness of the as needed lorazepam. There is no rational for the use of this medication at the current dose for R80. Review of an undated facility policy titled, "Psychotropic Medication Use Guidelines", identified all anti-anxiety medication administered to residents required facility staff to " quantitatively and objectively" document behaviors symptoms.	F 329		
F 353	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING	F 353		1/17/17

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F 353 SS=E	Continued From page 49 STAFF PER CARE PLANS 483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). [As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)] (a) Sufficient Staff. (a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. (a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. (a)(3) The facility must ensure that licensed	F 353		

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F 353	Continued From page 50 nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. (a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide sufficient nursing staff to meet assessed resident needs for 4 of 5 residents (R41, R49, R94 and R87) reviewed for activities of daily living, 1 of 3 residents (R94) reviewed for pressure ulcers, and for 4 of 4 residents (R3, R50, R80, R20) and 10 of 10 staff members (NA-A, NA-C, NA-B, TMA-A, NA-D, LPN-C, SM-A, SM-B, SM-B, RN-A) who voiced concerns with the lack of sufficient nursing staff in the facility. Findings include: ASSESSED RESIDENT NEEDS NOT BEING MET: See F282: The facility failed to ensure the plan of care was implemented for 4 of 5 residents (R41, R49, R94 and R87) reviewed who were dependent on staff for activities of daily living (ADLs). See F312: The facility failed to provide baths and timely toileting assistance for 2 of 3 residents (R41, R94) reviewed that were dependent upon staff for activities of daily living (ADLs).	F 353	F353- Sufficient 24 hour Nursing Staff Per Care Plans Talahi Nursing and Rehab Center assures sufficient staff to meet the needs of its residents. Community meetings were held with the residents in regards to their needs. Meetings were held with staff to determine the most appropriate allocation of hours. Review of call light response times to determine trends or patterns. Call light policy and procedure reviewed and is current. Information in regards to staffing procedures was communicated at Resident Council. Staffing information was shared at staff meeting. Staff re-educated to call light policy and procedure.	

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F 353	Continued From page 51 See F314: The facility failed to provide timely assistance for toileting and repositioning to reduce the risk of pressure ulcer development for 1 of 3 residents (R94) identified at risk of pressure ulcers. RESIDENT CONCERNS WITH LACK OF STAFFING: R3's quarterly Minimum Data Set (MDS) dated 8/23/16, identified R3 had intact cognition and required extensive assistance with ADLs. During interview on 12/5/16, at 3:12 p.m. R3 stated the facility lacked sufficient nursing staff to meet her needs timely. R3 stated the nursing staff were getting, "Sloppy on cares," because they had to rush through them due to not having enough staff. R3 stated she was incontinent of urine that same day because she didn't get help with toileting quickly enough adding it made her feel, "Upset and furious." R3's Device Activity Report dated 11/24/16 to 12/8/16, identified the following call light response times: - On 11/25/16, at 11:27 a.m. the call light was on for 22 minutes and 17 seconds; - On 11/25/16, at 1:46 a.m. the call light was on for 43 minutes and 35 seconds; - On 11/27/16, at 1:00 p.m. the call light was on for 18 minutes and 15 seconds; - On 11/28/16, at 7:58 a.m. the call light was on for 16 minutes and 25 seconds; - On 11/30/16, at 11:39 a.m. the call light was on for 15 minutes and 14 seconds; - On 11/30/16, at 6:52 p.m. the call light was on for 21 minutes and 8 seconds;	F 353	Education provided to direct care staff regarding best practice for toileting and bathing. Audits of staff and resident interviews will be conducted weekly in regards to staffing and meeting resident's needs. QAPI committee will review all audits for compliance at regularly scheduled meetings and make recommendations for continuance. DON/designee, Human Resources are responsible.	

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F 353	Continued From page 52 - On 12/2/16, at 8:37 a.m. the call light was on for 59 minutes and 20 seconds and; - On 12/2/16, at 12:35 a.m. the bathroom call light was on for 47 minutes and 45 seconds. R50's quarterly MDS dated 9/20/16, identified R50 had intact cognition and required extensive assistance with his activities of daily living (ADLs). During interview on 12/5/16, at 2:10 p.m. R50 stated the facility needed more staff to completed resident care. R50 stated he needs help to use the bathroom and, at times, has come, "Pretty close" to having incontinence because there is not enough staff to assist him promptly. R50's Device Activity Report dated 11/24/16 to 12/8/16, identified the following call light response times: - On 11/30/16, at 2:01 a.m. the call light was on for 23 minutes and 32 seconds; - On 11/30/16, at 11:42 a.m. the call light was on for 19 minutes and 28 seconds; - On 12/7/16, at 3:03 a.m. the call light was on for 16 minutes and 32 seconds and; - On 12/7/16, at 7:13 a.m. the call light was on for 20 minutes and 41 seconds. R80's annual MDS dated 11/15/16, identified R80 had intact cognition and required extensive assistance with ADLs. During interview on 12/5/16, at 2:30 p.m. R80 stated the facility was not adequately staffed. R80 stated she had waited up to 30 minutes for assistance before and at times just has to, "Hang on," to her bladder so she doesn't have	F 353		

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incontinence.

R80's Device Activity Report dated 11/24/16 to 12/8/16, identified the following call light response times:
- On 11/30/16, at 6:52 p.m. the call light was on for 22 minutes and 7 seconds;
- On 12/7/16, at 7:10 a.m. the call light was on for 18 minutes and 41 seconds and;
- On 12/7/16, at 11:36 a.m. the call light was on for 16 minutes and 54 seconds.

R20's quarterly Minimum Data Set (MDS) dated 10/6/16, identified R20 had moderate cognitive impairment.

During interview on 12/5/16, at 6:11 p.m. R20 stated the facility did not have enough staff to provide timely assistance with his needs. R20 stated he often has to wait up to 15 minutes for help, even after already asking for assistance. Further, R20 stated he had fallen in the hallway before and it took several minutes before staff responded to help him.

STAFF CONCERNS WITH LACK OF STAFFING:

During interview on 12/6/16, at 2:06 p.m. nursing assistant (NA)-A stated the facility is typically short staffed, "A couple times a week," and residents become upset their cares are not completed in a timely manner adding, "They [residents] can sense it." NA-A stated the resident baths are not always completed if they are short staffed and staff run around the facility, "Like chickens with their heads cut off," trying to get cares completed.

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F 353	Continued From page 54 When interviewed on 12/6/16, at 2:28 p.m. NA-C stated the nursing staff was, "Really short," some days and being full staffed with four aides on the main unit of the facility was not consistently happening anymore adding, "We're lucky if we get four aides." NA-C stated it was difficult to complete all of the assigned cares for residents, like bathing, because of the lack of staffing. NA-C stated the residents, "Get really upset," when their baths and cares aren't completed. Further, NA-C stated several staff had reported the concerns with lack of sufficient staff to the nurse managers and administration of the facility, however, staff are just told, "We're working on it." During interview on 12/6/16, at 2:45 p.m. NA-B stated the memory care unit is typically staff with just two NA staff and a cart nurse. NA-B stated the memory care unit used to be staffed with three NA staff though, however, it was changed because administration felt people were just, "Standing around down here." NA-B stated two NA staff was not enough to care for the residents adequately or safely, "You need to have three aides because of the behaviors we have." NA-B stated resident care was suffering as a result of the lack of sufficient staffing adding, "They're [resident] not getting bathed," consistently. Further, NA-B stated these concerns regarding the lack of staff had been, "Voiced strongly," to managers and administration. When interviewed on 12/6/16, at 3:22 p.m. trained medication aide (TMA)-A stated the facility typically would only staff, "The bare minimum of what we need," and cares were suffering as a result. TMA-A stated the facility was short staffed, "At least twice a week," and residents	F 353		

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had been complaining about their baths and other cares not being completed.

During interview on 12/7/16, at 4:03 p.m. NA-D stated the memory care unit was supposed to be staffed with three NA staff and a cart nurse. NA-D stated if they did not have full staffing for the day, then cares suffer and were, "Not that good." Further, NA-D stated residents' range of motion and bathing was not always completed if they were short staffed adding, "Sometimes you can get it, sometimes you can't."

When interviewed on 12/7/16, at 4:47 p.m. licensed practical nurse (LPN)-C stated several residents had voiced concerns about a lack of 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, "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 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 number of NA staff and, "RN/LPN/TMA" staff to

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have provide care for each shift. The chart identified the following desired staffing levels for a facility census of 70 (as it was during the survey):

- 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 AM shift: 3.5 - 3.6
- Nurse/TMA for PM shift: 3.5 - 3.6
- Nurse/TMA for night shift: 2.0

During an anonymous interview on 12/7/16, a staff member (SM)-A stated the facility was short staffed and baths, "Usually don't get done," as a result. Further, SM-A stated residents had voiced concerns to them about the lack of staff in the facility adding these complaints were heard, "A few times a week."

During an anonymous interview on 12/7/16, SM-B stated the staff end up working short staffed a, "Couple times a week," which results in call lights being answered slower and cares not being provided consistently. SM-B stated the facility used to have pool staff available which was helpful because, "At least [you] had that person there," to help with cares. SM-B stated the staff report these concerns to the nurses, but are just told, "Try to do your best." Further, SM-B stated they were unaware of anything being done by administration to handle or address the lack of staffing in the facility.

During another anonymous interview on 12/8/16, SM-C stated the facility administration had restructured the facility staffing a couple months prior and each unit should have at least two aides working. In addition, two bath aides were being

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F 353	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, however, added she didn't feel there was enough of a concern to justify changing the staffing levels in the facility. Further, the administrator stated the facility was looking at moving to a primary care nursing model and	F 353		

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F 353	Continued From page 58 staffing would be adjusted to reflect this. A facility Nursing Department Staffing policy dated 12/2010, identified an objective, "To provide adequate staffing for the nursing floor," and directed staff to use daily check in sheets to assign scheduled nursing staff to work groups, and attempt to replace a call in if one occurs.	F 353		
F 364 SS=B	483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP (d) Food and drink Each resident receives and the facility provides- (d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; (d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure prepared foods were flavorful when served for 1 of 1 residents (R69) who complained about poor tasting food. This had potential to affect 10 of 10 residents identified by the facility as having received the meal. Findings include: R69's quarterly Minimum Data Set (MDS) dated 10/22/16, identified R69 had moderate cognitive impairment. During observation of the Rosewood Unit evening meal service on 12/5/16, at 6:18 p.m. dietary aide	F 364	F364- Nutrition Value/Appearance/Preference Talahi Nursing and Rehab Center does serve food and drink that is palatable. The garlic bread has been replaced on the food order with prepackaged garlic bread. The Dietary Director has been re-educated on food palatability. The food council meets on a monthly basis at which time any concerns can be brought to the attention of dietary.	1/17/17

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F 364	Continued From page 59 (DA)-A wheeled a mobile cart into the kitchenette to begin serving the meal. DA-A placed a metallic serving pan into the steam table which contained a loaf of sliced white bread with only its top crusts exposed. DA-A began to plate food by removing single pieces of bread from the pan and placing them on several different plates to be served. The bread sagged downward as DA-A removed it from the pan with only the top portion of crust on each piece having visible yellowing coloring or seasoning. DA-A served plates with this bread on it to several residents along with pizza and salad. When DA-A finished serving resident trays, a sample tray was requested by the surveyor. The bread was not toasted, but rather soft and limp, with only visible yellow seasoning on the top crust. The surveyor tasted the bread and it lacked any garlic flavor. When interviewed on 12/5/16, at 6:55 p.m. DA-A stated the white bread was supposed to be garlic toast, however, "Just the top of the bread" appeared to have any seasoning or coloring adding, "I think it could use a little bit more garlic." Further, DA-A stated she served the bread to approximately ten residents during the meal service. When interviewed on 12/5/16, at 6:56 p.m. R69 stated the garlic bread served for the evening meal lacked flavor and was not very good, "I've tasted better." During interview on 12/7/16, at 3:28 p.m. the dietary director (DD) stated the cook had prepared the garlic toast incorrectly adding she, "Didn't like the way it looked" when it was served. DD stated the cook should have laid each piece	F 364	QAPI committee will review all audits for compliance at regularly scheduled meetings and make recommendations for continuance. Dietary Director is responsible.	

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F 364	Continued From page 60 out and buttered it separately to, "Get more butter on the bread and more flavor." A facility supplied Garlic Bread Recipe Preparation dated 12/7/16, directed cooking staff to, "Brush melted margarine on each slice of bread," for serving. An undated facility Residents' Rights and Responsibilities Related to Food Service Operations policy, undated, identified residents should be served, "...nourishing, palatable, and well-balanced meals that meet daily nutrition and special needs."	F 364		
F 365 SS=D	483.60(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS (3) Food prepared in a form designed to meet individual needs; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and provide an appropriately textured diet for easy consumption for 1 of 1 residents (R57) who had difficult chewing a regular diet. Findings include: R57's quarterly Minimum Data Set (MDS) dated 10/15/16, identified R57 had moderate cognitive impairment, was independent with eating and had no identified swallowing disorders. During interview on 12/5/16, at 5:07 p.m. R57 stated she had recently lost a tooth and was concerned about it. R57 showed the surveyor her teeth which had visible teeth missing on the	F 365	F365 Food in Form to Meet Individual Needs Talahi Nursing and Rehab Center prepares food in a formed design to meet individual needs. R57 has been evaluated by the dietician for mastication needs and the care plan has been updated to include dietician recommendations. R57 weight and intake are monitored on a regular basis. Dietary Director has reviewed all consistency diets to ensure residents are	1/17/17

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F 365	Continued From page 61 upper palate, with several additional teeth broken off at the gum line on her lower palate. R57 stated it was more difficult to chew her food lately without all of her teeth adding she has, "To be careful" with eating now. During observation of the evening meal service on 12/5/16, at 7:25 p.m. R57 was standing up next to the dining room table. R57 had been served a hamburger and bun, however R57 had only eaten approximately 1/2 of the hamburger and left the other half uneaten on the plate. R57 stated she couldn't keep eating it because it was too hard to chew, "Because of the teeth," as she motioned with her hand to her mouth. R57's Regulatory Visit note dated 11/11/16, identified R57 had been anxious and fixated about, "Dental problems" with teeth having fallen out a month prior. R57's Patient Progress Note dated 10/4/16, was completed by the dentist and identified R57 to have, "Several teeth fractured off at the gumline," adding R57, "States she is having trouble chewing as she is missing so many posterior teeth." Further, the note had a handwriting at the bottom which was dated 10/27/16, and identified the family did not want extensive dental work completed for R57. The note lacked any identified plan to address R57's complaints of difficulty chewing her food. R57's Dietary Assessment dated 10/15/16, identified R57 consumed a regular diet with no texture restrictions and, "No chewing or Swallowing problems" being circled on the assessment. However, the assessment had a separate section labeled, "Notes" which identified	F 365	receiving diets to match their mastication abilities. Concerns identified have been referred to appropriate discipline. ie: ST, Dietician, MD, DDS. Three audits per week for three weeks will be conducted during meal times to identify residents whom may be having difficulty masticating. In-services were conducted with nursing staff to ensure they are identifying and endorsing issues like difficulty chewing to management. QAPI committee will review audits for compliance at regularly scheduled meetings and make recommendations for continuance. DON/designee, Dietary Manger, Dietician responsible	

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she had been seen by the dentist on 10/4/16 with, "Several teeth fractured off [at] gumline, trouble chewing." The assessment lacked any identified plan to address R57's complaints of difficulty chewing her food, or to modify her diet so it was easier for R57 to chew and eat her meal.

During interview on 12/6/16, at 2:23 p.m. nursing assistant (NA)-A stated R57 received a regular diet at meals and had only been eating, "Anywhere from 25 to 75 percent" of her meals lately adding she had, "Never seen her finish all her food." Further, NA-A stated she was unaware R57 had made any complaints about having trouble chewing her food.

When interviewed on 12/6/16, at 3:29 p.m. speech language pathologist (SLP)-A stated speech had not worked with R57, "In the last few months." SLP-A stated she was unaware R57 was having any troubles chewing her food adding, "This is the first I've heard of it." SLP-A stated the repeated concerns of trouble chewing should have been forwarded to her so they could be addressed as R57 was at a nutritional risk and could potentially just stop eating if she was having trouble chewing, "This is something I would have expected nursing to pass on."

When interviewed on 12/7/16, at 11:45 a.m. registered nurse (RN)-B stated she had reviewed R57's weight and intakes and did not feel R57's concern with difficulty chewing was, "Something that had to be addressed," because her intakes were stable. Further, RN-B stated there had been no assessment or plan to address R57's complaints of trouble with chewing her food adding R57, "Appears to be chewing and swallowing just fine."

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F 365	Continued From page 63 No further information was provided.	F 365		
F 371 SS=F	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure left-over foods were discarded timely and cooking equipment was maintained to reduce the risk of food borne illness for 66 of 70 residents who consumed the food prepared in the kitchen. The facility also failed to ensure expired and opened nutritional	F 371	F371- Food Procedure/Storage/Sanitary Talahi Nursing and Rehab Center does store food in accordance with professional standards for food service safety. During survey all out dated food was	1/17/17

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supplements were not served to 8 of 8 residents (R94, R93, R98, R95, R92, R91, R90, R28) whose nutritional supplements were stored in medication rooms.

Findings include:

FACILITY KITCHEN
An tour of the facility kitchen was completed on 12/5/16, at 11:58 a.m. with the dietary director (DD). The following items were noted in the facility walk in cooler:

- 31-ounce container, of cherry topping dated 11/3/16
-Two-quart container, 1/2 full, of cream style corn dated 11/21/16
-Two hot dogs in a gallon bag dated 11/21/16
-Two quart container 1/8 full of of mixed fruit dated 11/22/16
-Two-quart container, 3/4 full, of fruit cocktail dated 11/22/16
-Two-quart container of peaches, containing approximately 1 1/2 cups, dated 11/24/16
-Two-gallon container, full of sweet potatoes dated 11/24/16
-Two -gallon container of bread stuffing dated 11/24/16
-Three-gallon container of turkey stock dated 11/25/16

During an interview on 12/5/16 at 12:03 p.m., the dietary director (DD) stated the dietary supervisor or chefs were responsible to check for outdated items on a weekly basis. The DD stated that food items can be used up to seven days after initial use, per facility policy.

Also observed during the initial tour on 12/5/16 at

F 371

discarded.

The identified nonstick frying pans were discarded during the survey.

All opened unlabeled undated cans of ensure and jevity were discarded during the survey.

Staff have been re-educated open containers are not allowed to be stored, unused portions must be discarded immediately.

Daily audits are conducted by the cooks to ensure no outdated food is in the kitchen.

The Dietary Manager conducts three audits per week for the next two months to ensure there is no outdated food in the kitchen.

Medication rooms are audited three times a week for the next two months to ensure there are no opened unused cans of ensure or jevity.

Results of the audits will be relayed and discussed at the monthly IDT/QA meeting.

DON/designee and Dietary Manager are responsible.

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F 371	Continued From page 65 12:03 p.m. were two non-stick frying pans on a shelf. The non-stick coating material, over approximately 3/4 of the surface area of both frying pans, was missing and had multiple scratches which exposing the non-stick surface to food items. During an interview on 12/5/16 at 12:03 p.m. the DD stated the non-stick fry pans were used to cook up small quantities of food. She would normally dispose the scuffed pans, but was hesitant to do so related to a delay in replacement of equipment. During a subsequent interview on 12/7/16, at 1:08 p.m., the DD stated the left-over turkey stock and sweet potatoes were from Thanksgiving. They were going to use these items to make soup or gravy stock for future resident meals. The DD stated both items would make approximately ninety-six 1/2 cup servings of soup for the resident in the facility. During an interview on 12/8/16 at 3:30 p.m. registered dietitian (RD) stated leftover food items should be used in three days or less because of "...the increased risk of food-borne illness." Although the facility RD identified they had to use leftover food items in three days or less, the items identified in the facility walk in cooler were there 32 to 10 days since being opened. A facility policy, undated, titled "Food Storage," dated 2009 indicated "Leftover food is used within 7 days or discarded." MEDICATION ROOMS During observation on 12/05/16, at 5:10 p.m. of	F 371		

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F 371	Continued From page 66 the west medication room there were two opened and undated/unlabeled cans of Ensure (nutritional shake) for R93, R96, R26 and one can of Jevity (nutritional shake) for R94, initialed, but had no opened date. During observation on 12/05/16, at 6:57 p.m. of the North medication storage room an one opened unlabeled/undated can of Ensure for R90. When interviewed on 12/05/16, at 6:57 p.m. registered nurse (RN)-A examined the opened cans of Ensure/Jevity in the North and West medication refrigerators and stated Ensure/Jevity was only good for 24 hours after it is opened. She had "no way of knowing" how long the supplements had been in the refrigerator. Further, RN-A stated all open supplements should have the residents initials and date they were opened to prevent them from being used after their expiration date. During interview on 12/06/16, at 8:49 a.m. the director of nursing stated all supplements should be dated/initialed when opened as they expired within 24 hours after being opened. Review of Abbot manufacturers packet insert, dated 11/2016, for Jevity and Ensure, indicated supplements expire within 48 hours after being opened. A policy for expiration of house supplements was requested, but was not provided during the survey.	F 371		
F 387 SS=D	483.30(c)(1)(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT	F 387		1/17/17

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(c) Frequency of Physician Visits

(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter.

(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.
This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to ensure that physician visits were provided at least once every 30 days for the first 90 days after admission for 1 of 5 residents (R31) who were newly admitted to the facility.

Findings include:

R31's admission minimum data set (MDS), dated 8/26/16, indicated no cognitive impairment.

R31's hospital discharge report, dated 8/19/16, indicated she had been admitted to the facility following a hospital stay related to leg pain. R31's diagnosis list, dated 12/7/16, identified an admission diagnoses of cellulitis (skin infection) along with a history of diabetes with nephropathy (kidney damage), heart failure, and chronic obstructive pulmonary disease.

A review of physician and physician assistant (PA) notes identified the following:

- On 8/31/16, R31 received a visit and was assessed by her from her primary physician. The note indicated that R31 needed monthly visits due to her "Advanced multiple co-morbid conditions

F387- Frequency/Timelines of Physician Visits

Talahi Nursing Rehab Center assures residents are seen in a timely manner in accordance with rules and regulations.

R31 has been seen by a physician and is followed by the physician on a regular basis.

Talahi Nursing and Rehab Center has contracted with new Medical Director to begin 1/1/2017 who is committed to seeing our residents in a timely manner.

A calendar has been established to track timely physician services for all new admissions, it is maintained daily by the Health Unit Coordinator and reviewed weekly by the DON.

QAPI committee will review audits for compliance at regularly scheduled meetings and make recommendations for continuance.

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with multiple medications" and that "Given long-term placement in skilled nursing facility will need to transfer care."

- 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 would stop seeing a patient when admitted 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

DON/designee, Social Service, Admissions, HUC are responsible.

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F 387	Continued From page 69 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 ultimately responsible for overseeing R31's care. A facility copy of the Combined Federal and States Bill of Rights, dated 11/28/16, directed the facility would seek alternate physician services to "Assure provision of appropriate and adequate care and treatment."	F 387		
F 425 SS=E	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure tuberculin solution was available for resident and staff use and were not expired. This had potential to affect 3 of 9 residents (R94, R93 and R98) who received the expired solution. In addition, the facility failed to ensure medications were given according to manufactures instructions for 1 of 1 residents (R94).	F 425	F425- Pharmaceutical Services Talahi Nursing Rehab Center does provide pharmaceutical services to meet the needs of each resident. All opened and undated TB PPD vials were discarded during survey.	1/17/17

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F 425	Continued From page 70 Findings include: EXPIRED TUBERCULIN SOLUTION On 12/05/16, at 05:10 p.m. the West medication storage room was observed with registered nurse (RN)-D. The West medication storage refrigerator contained an opened package of Tuberculin Purified Protein Derivative (TB) (a medication used to test for exposure to Tuberculosis) with an expiration date of 10/10/16, written on the vial. RN-D stated the tuberculin solution was available for residents and facility staff. Further, RN-D stated expired TB solution should not be administered after the expiration date because it could cause an "inaccurate result." Upon review of documentation titled, "Baseline TB Screening for nursing home and boarding residents" R94 was given an expired TB test (lot number 772984) on 12/1/16, 21 days after it expired. R93 was given expired TB solution (lot number 772984) on 11/22/16, 12 days after it expired and R98 was administered TB test (lot number 772984) on 11/21/16, 11 days after it expired. On 12/05/16, at 05:36 p.m. the Rosewood medication storage room was observed with assistant director of nursing RN-A. A refrigerator inside the medication room contained an opened package of Tuberculin Purified Protein Derivative with no expiration date written on the vial. RN-A stated the tuberculin solution was available for residents. Further, RN-A stated the TB solution should have been discarded after 30 days from being opened and they had no way of knowing when the solution was opened.	F 425	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 TB PPD is dated. R94 mybetriq was discontinued. DON/designee is responsible to review each MAR on admission to assure proper method of administration is noted. QAPI committee will review audits for compliance at regularly scheduled meetings and make recommendations for continuance. DON/designee is responsible.	

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F 425	Continued From page 71 During interview on 12/06/16, at 8:49 a.m. director of nursing (DON) stated the tuberculin solution should have been discarded after being opened for thirty days because the medications effectiveness could be decreased. A facility policy on expiration dates for TB solution was requested, but was not provided during the survey. MANUFACTURE GUIDELINES: 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 of the mouth. R94's Dismissal Summary from Mayo Clinic dated 12/1/16, indicated R94 had dysphagia (difficulty swallowing) and had a peg (percutaneous endoscopic gastrostomy, which is placed in abdominal wall and stomach to allow nutrition, fluids and/or medications to put directly into the stomach, bypassing the mouth and esophagus) tube placed. Further, R94 was to receive myrbetriq (medication for treatment of overactive bladder) 25 milligrams (mg) sustained release (designed to release medication in body over a extended period of time) by mouth every morning. A speech therapy (ST) Plan Of Care, dated 12/02/16, indicated R94 was unable to swallow on command and had no spontaneous swallow noted. During observation 12/07/16, at 10:40 a.m.	F 425		

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listened practical nurse (LPN)- D set up R94's medications. LPN-A crushed all of R94's medications except for THE myrbetriq. LPN-D stated the medication was "sustained released" and could not be crushed, and was ordered to be given by mouth. LPN-D entered R94's room and administered R94's medications, except myrbetriq, via peg tube. LPN-A then stated she would not be able to give R94 myrbetriq because she was uncertain if R94 could swallow the pill.

During interview 12/07/16, at 1:00 p.m. LPN-D stated she spoke with R94's physician who discontinued myrbetriq. LPN-D also stated R94 had received the myrbetriq five times since admission, but was uncertain how the staff administered this medication to R94.

During interview 12/08/16, at 9:15 a.m. the director of nursing (DON) stated the staff must have been giving the myrbetriq by crushing it, and administering it via the peg tube. The DON stated the nurses should have clarified this order with R94's physician.

During a subsequent interview on 12/08/16, at 9:21 a.m. LPN-D stated she had given R94 myrbetriq by crushing it and giving it via R94's peg tube.

A facility policy was requested on giving medications according to manufacture specifications and was not received.

A Patient Information from the manufacture Astellas Pharma US, Inc. revised August 2016, instructed patients "You should take Mybetriq with water and swallow the tablet whole. Do not crush or chew the tablet".

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F 431 SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		1/17/17

The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--

(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

(g) Labeling of Drugs and Biologicals.
Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

(h) Storage of Drugs and Biologicals.
(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in

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F 431	Continued From page 74 locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure insulin and tuberculin solution bottles were dated when open, and expired Novolin, Novolog, Levemir, and Lantus insulin (medication used to treat diabetes) vials were removed from medication carts and not administered to 2 of 11 residents (R2, R31) who used insulin within the facility. Further, facility failed to ensure tuberculin solution was available for resident and staff use and were not expired. This had potential to affect 3 of 9 residents (R93, R98 and R95) who received the expired solution. Findings include: INSULIN R2's quarterly Minimum Data Set (MDS) dated 10/28/16, identified R2 had type two diabetes mellitus (metabolic disease causing increase blood glucose levels and may require insulin). Review of R2's undated physician's orders identified R2 received Novolog (insulin used for	F 431	F431- Drug Records, Label/Store Talahi Nursing and Rehab Center does provide pharmaceutical service to meet the needs of each resident. R2 and R31 insulin were discarded at time of the survey. All insulin is dated when opened. Staff have been re-educated to the procedure of opening and dating insulin. Med carts will be audited two times a week for three weeks to ensure all insulin that is opened is dated. All opened and undated TB PPD vials were discarded during survey. The PPD was all relocated to one refrigerator at the north med room.	

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diabetes) 90 units subcutaneous (SQ) in the morning and 56 units in the evening. R69's quarterly Minimum Data Set (MDS) dated 10/22/16, identified R69 had type two diabetes mellitus (metabolic disease causing increase blood glucose levels and may require insulin).

R31's quarterly Minimum Data Set (MDS) dated 11/19/16, identified R31 had type two diabetes mellitus (metabolic disease causing increase blood glucose levels and may require insulin). Review of R31's undated physician's orders identified R31 received Novolog (insulin used for diabetes) 5 units subcutaneous (SQ) three times a day with meals and 4 units per each carbohydrate four times a day.

During observation of the medication cart 12/06/16, at 11:57 a.m. R2's Humulin insulin had a delivery date from the pharmacy on 10/25/16 and R31's Levemir insulin had a delivery date of 10/22/16.

When interviewed on 12/05/16, at 12:25 p.m. nursing assistant (NA)-L stated she did not observe an expiration date on R2's, R31's insulin. Further, NA-L stated there were no other insulin's for these residents on the medication cart which she (NA-L) was aware of.

During interview 12/5/16, 6:43 p.m. registered nurse (RN)-A stated once a resident's insulin was opened it should be labeled with an expiration date as it was only good for 30 days after it has been opened.

A review of a the manufacturers instructions from Elli Lilly instructs to discard Humulin insulin expired 30 days after it is opened. Further, a

Audits are conducted weekly the DON/designee to assure all opened TB PPD is dated.

R94 Mybetiq was discontinued.

DON/designee is responsible to review each MAR on admission to assure proper method of administration in noted.

QAPI will review audits for compliance at regularly scheduled meetings and make recommendations for continuance.

DON/designee is responsible.

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review of manufacturers instructions from Norvo Nordisk stated Levemir insulin is expired after 42 days after it is opened.

TUBERCULIN:

On 12/05/16, at 05:10 p.m. the West medication storage room was observed with registered nurse (RN)-D. The West medication storage refrigerator contained an opened package of Tuberculin Purified Protein Derivative (TB) (a medication used to test for exposure to Tuberculosis) with an expiration date of 10/10/16, written on the vial. RN-D stated the tuberculin solution was available for residents and facility staff. Further, RN-D stated expired TB solution should not be administered after the expiration date because it could cause an "inaccurate result

Upon review of documentation titled, "Baseline TB Screening for nursing home and boarding residents" R94 was given an expired TB test (lot number 772984) on 12/1/16, 21 days after it expired. R93 was given expired TB solution (lot number 772984) on 11/22/16, 12 days after it expired and R98 was administered TB test (lot number 772984) on 11/21/16, 11 days after it expired.

During observation on 12/05/16, at 05:36 p.m. of the Rosewood medication storage room with assistant director of nursing RN-A. A refrigerator inside the medication room contained an opened package of Tuberculin Purified Protein Derivative with date of when the vial was opened. RN-A stated the tuberculin solution was available for resident use, but was unsure who received the tuberculin solution. Further, RN-A stated the TB solution should have been discarded after 30

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F 431	Continued From page 77 days from being opened but they had not way of knowing when the solution was opened since it was not dated. A facility policy on expiration dates for TB solution was requested, but was not provided during the survey. A facility policy titled,"Medication Administration and Storage" dated 3/24/2016, identified, "Insulin is to be dated on the vial or tube when opened." Further, the policy stated to check medication carts for outdated medications weekly.	F 431		
F 441 SS=F	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections	F 441		1/17/17

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	245438	A. BUILDING ______ B. WING ______	C **12/08/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 78 before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an	F 441		

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F 441	Continued From page 79 annual review of its IPCP and update their program, as necessary. This 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: 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."	F 441	F441- Infection Control Talahi Nursing and Rehab Center maintains an infection prevention program. Infection control policies and procedures 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 weekly 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. Nurses have been re-educated on the clean dressing change technique. Random audits will be conducted on staff whom complete dressing changes to ensure proper technique is followed. QAPI committee will review audits for compliance at regularly scheduled meetings and make recommendations for continuance.	

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In addition, several Centracare Laboratory Services reports dated 9/1/16, through 9/30/16, identified different cultures of collected specimens. The reports identified three different residents had urine samples cultured with the same bacteria, however lacked any information on the date of symptom onset, resolution, or if the infection was determined to be community or in-house acquired.

DON/designee is responsible.

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.

OCTOBER 2016:

An Order Listing Report dated 12/5/16, identified six residents had received antibiotics during the month for different diagnosis which included chronic pain syndrome, pneumonia, yeast, and severe sepsis. The report lacked any dates of symptom onset or resolve, organism cultures, room numbers, or if the infection was determined to be community or in-house acquired.

An undated Infection Report Form identified a 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

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F 441	Continued From page 81	F 441		

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 spreading in the facility.

There was no further information provided for any of the identified months of data.

When interviewed on 12/7/16, at 3:36 p.m. the director of nursing (DON) stated the person who had been in charge of the program was no longer employed at the facility and they were in the process of being reassigned to someone else to

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F 441	Continued From page 82	F 441		

oversee. Further, the DON stated the infection control program lacked consistent monitoring, trending or analysis of the collected data adding, "We have to come to a better system," and, "Have better tracking of that [infections in the facility]." Further, the DON stated she had been aware the program was lacking these components for the past couple weeks.

During interview on 12/8/16, at 10:32 a.m. the administrator stated staff were, "Always watching" for infections during their regular meetings throughout the week, however do not start any processes for tracking or trending unless patterns of infection are being noted, "I look for the pattern."

A facility Infection Control Program policy dated 2/16/16, identified an objective which included, "Help prevent the development and transmission of disease and infection." The policy identified several elements of the facility program which included, "Surveillance based on systemic data collection," and having, "A system for detection, investigation, and control of outbreaks of infectious disease." Further, the policy identified summaries of the infections were to be compiled and analyzed by the infection control committee, with findings being communicated to determine if changes in practice or procedures were required.

HAND HYGIENE
R39's admission Minimum Data Set (MDS) dated 7/12/16, identified R39 was cognitively intact with a diagnosis of congestive heart failure and an right above the knee amputation. On 10/17/16, R39's significant change in status MDS identified R39 had an unstageable pressure ulcer on R39's left heel and another on his coccyx.

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F 441	Continued From page 83 R39's treatment administration record identified a physician order on 11/04/16, for "Dressing change to left heel: Clean open area with normal saline, dry. Cover with Melgisorb dressing. Change daily and on an as needed basis." During observation on 12/07/16, licensed practical nurse (LPN)-A donned a set of clean gloves. With her clean gloves, LPN-A took off the soiled bandage from R39's left heel and threw it in the trash. Without first removing her soiled gloves, LPN-A-A obtained a new bandage and accidentally dropped it on the floor. She grabbed the bandage off the floor and obtained a pen from her (LPN-A's) pocket to mark a date on the dressing without first removing her soiled gloves. With her same soiled gloves, LPN-A irrigated R39's left heel pressure ulcer. After irrigating R39's left heel, R39 placed his clean heel unto the soiled bed linen. With her same soiled gloves, she placed a new clean dressing over R39's left heel and then removed her soiled gloves. LPN-A than proceeded to wash her hands in R39's bathroom. When interviewed on 12/07/16, at 7:33 a.m. licensed practical nurse (LPN)-A stated she contaminated the pressure ulcer on R39's left heel after she (LPN-A) touched the ground and dug in her pocket with her gloved hands. LPN-A stated R39's heel should have not touched the bed after being irrigated because it increased R39's risk for an infection. Further, LPN-A stated it is important to don on a clean set of gloves when working with pressure ulcers because there was a higher risk of "contaminating " the area and an increased risk of infection. During interview on 12/07/16, at 11:18 a.m. the assistant director of nursing (ADON)-A stated wearing dirty gloves could contaminate the area	F 441		

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F 441	Continued From page 84 and increased the risk of infection to R39's pressure ulcer on his left heel. When interviewed on 12/07/16, at 11:43 a.m. the director of nursing stated it was "inappropriate " to wear soiled gloves during pressure ulcer treatment as it could increase the risk of infection to the pressure ulcer on R39's left heel. A policy regarding hand hygiene was requested, but not provided during the survey.	F 441		
F 501 SS=D	483.70(h)(1)(2) RESPONSIBILITIES OF MEDICAL DIRECTOR (h) Medical director. (1) The facility must designate a physician to serve as medical director. (2) The medical director is responsible for- (i) Implementation of resident care policies; and (ii) The coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to collaborate with the medical director to address concerns of physician continuity for 1 of 1 residents (R31) who did not receive medical care under a consistent physician. Findings include: R31's admission minimum data set (MDS), dated 8/26/16, indicated no cognitive impairment.	F 501	F501- Responsibilities of the Medical Director Talahi Nursing and Rehab Center assures resident are seen in a timely manner in accordance with rules and regulations. R31 has been seen by physician and is followed by the physician on a regular basis. Talahi Nursing and Rehab Center has	1/17/17

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F 501	Continued From page 85 R31's hospital discharge report, dated 8/19/16, indicated she had been admitted to the facility following a hospital stay related to leg pain, which also indicated a follow up appointment with her primary physician at the facility in one week. R31's diagnosis list, dated 12/7/16, further identified an admission diagnosis of cellulitis (skin infection) along with a history of diabetes with nephropathy (kidney damage), heart failure, and chronic obstructive pulmonary disease. A review of physician and physician assistant (PA) notes identified the following: On 8/31/16, R31 received a visit and was assessed by her primary medical doctor (MD-B). The note indicated that R31 needed monthly visits due to her "Advanced multiple comorbid conditions with multiple medications" and that "Given long-term placement in skilled nursing facility will need to transfer care." On 10/17/16, 47 days after her last physician visit, R31 had an appointment to establish care with a different physician, MD-C outside the facility who assessed R31. The note identified MD-C would be contacting the facility to "Clarify the issue concerning R31's non-eligibility for in-facility care." On 10/24/16, MD-C declined to take R31 as a patient recommending an Internal Medicine Provider, and offered to place referral for the facility. On 11/3/16, 76 days after her admission, R31 had an appointment with a PA-A. After assessing R31, the PA-A also declined to take R31 as a patient due to her complex medical history and recommended an Internal Medicine Physician.	F 501	contracted with a new Medical Director to begin 1/1/2017 who is committed to seeing our residents in a timely manner. A calendar has been established to track timely physician services for all new admissions, it si maintained daily by the HUC and reviewed weekly by the DON. QAPI committee will review audits for compliance at regularly scheduled meetings and make recommendations for continuance. DON/designee, Social Services, Admissions, HUC are responsible.	

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F 501	Continued From page 86 On 11/18/16, 91 days after she was admitted, R31 had an appointment with a MD-D outside the facility who completed an assessment of R31 and became her primary physician. A facility Progress Note, dated 9/26/16, indicated the facility had requested the facility's Medical Director (MD)-A to follow R31 starting 9/27/16, because they were unable to find a physician for R31. A Progress Note, dated 10/26/16, indicated the facility Medical Director-A had declined to follow R31 as a patient. R31's medical record lacked any indication the Medical Director-A had completed an assessment of R31 in September, when R31 was not seen within 30 days of her last physician assessment. There was also no indication the Medical Director-A had been contacted to assist R31 to establish care with a primary physician. 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. R31 stated she hadn't been seen by the Medical Director, but had been told he couldn't follow her due to age and insurance. R31 stated since the facility's Medical Director wouldn't see her, she "was hanging again" and was "Just hoping and praying things got better." During interview on 12/7/16, at 5:29 p.m. MD-A stated he wasn't able to take R31 as a patient due to her younger age. He further stated he hadn't seen R31 in person in September, just reviewed her chart and thought she was already referred to another physician. The MD-A was unaware R31 had not been assessed by a	F 501		

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F 501	Continued From page 87 physician in September or that she was denied care twice. The MD-A would have expected the facility to contact him when R31 was denied care stating he was ultimately responsible for her care. During interview on 12/8/16, at 11:03 a.m. director of nursing (DON) stated MD-A should have been involved in finding care for R31 since he had refused to follow her as her primary physician. The facility's Medical Director Agreement, reviewed 1/29/16, identified the responsibilities to include the "Overall coordination of medical care in the facility to ensure the adequacy and appropriateness of the medical services provided to residents."	F 501		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
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F 156	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES

(d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care.

§483.10(g) Information and Communication.
(1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility.

(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including:

(i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes -

(A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section;

(B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act.

(C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and

(D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.

(ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.)
[§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)]

(iii) Information regarding Medicare and Medicaid eligibility and coverage;
[§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)]

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

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F 156	Continued From Page 1

(iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program;
[§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)]

(v) Contact information for the Medicaid Fraud Control Unit; and
[§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)]

(vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.

(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives:

(i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and

(ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community.

(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 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 resident with the State-developed notice of Medicaid rights and obligations, if any.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND 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**	STREET ADDRESS, CITY, STATE, ZIP CODE **1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-

(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 resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section.

(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.

(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.

(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.

(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.

(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.

v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.
This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to provide the appropriate liability notice to 2 of 6 residents (R64 and R91) reviewed who were discharged from Medicare services.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND 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**	STREET ADDRESS, CITY, STATE, ZIP CODE **1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES

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Continued From Page 3

Findings include:

R64's admission Minimum Data Set (MDS), dated 10/28/16, indicated R64 received physical and occupation therapy while admitted in the facility.

R64's was provided and signed a Notice of Medicare Non-Coverage CMS 10095 (which explains a resident's right to an immediate appeal through the QIO or Quality Improvement Organization) on 11/4/16, identifying R64's Medicare services were ending on 11/7/16. R64 was discharged from the facility on 11/8/16. R64's received notice form CMS 10095, which identified Straits Health as the QIO. R64 should have received the form CMS 10123, and not the CMS 10095, which was the incorrect 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.

R91 received and signed liability notice form CMS 10095 on 11/22/16, regarding Medicare services ending on 11/24/16. Since R91 remained in the facility, he also received the a SNF determination on continued stay (which explains a resident's financial obligations when Medicare services end). R91 should have received the form CMS 10123, and not the CMS 10095, which was the incorrect 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 CMS 10095 form, expired 10/31/2013, over three years ago, and had been replaced with the CMS 10123.

A copy of the facility's policy was requested, but not provided.

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

F5438027

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245438	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	12/07/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division 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	K 000		

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

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

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	(X3) DATE SURVEY COMPLETED
	245438	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**12/07/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 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		

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

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

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

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

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

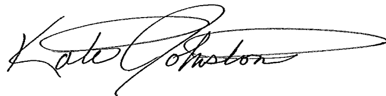
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting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

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

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

Please feel free to call me with any questions.

Sincerely,



Kate JohnsTon, Program Specialist
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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00614	A. BUILDING: ______ B. WING ______	C **12/08/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 12/05/16 through 12/08/16, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. In addition, an investigation of complaint H5438047 was completed and substantiated with a deficiency cited at F353 during the survey. An investigation of complaint H5438046 was completed, and found to be unsubstantiated.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 notice of assessment for non-compliance.

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 12/05/16 through 12/08/16, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. In addition, an investigation of complaint H5438047 was completed and substantiated with a deficiency cited at F353 during the survey. An investigation of complaint H5438046 was completed, and found to be unsubstantiated.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the plan of care was implemented for 4 of 5 residents (R41, R49, R94 and R87) reviewed who were	2 565	Completed	1/17/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00614	A. BUILDING: ______ B. WING ______	C 12/08/2016

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

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2 565	Continued From page 2	2 565		

dependent on staff for activities of daily living (ADLs).

Findings include:

BATHING
R41's quarterly Minimum Data Set (MDS) dated 11/21/16, identified R41 was moderately cognitively impaired and required total assistance from facility staff for activities of daily living (ADL)'s. In addition, R41 had no rejection of ADL's during the MDS assessment period.

R41's plan of care, dated 10/06/16, noted R41 had an identified problem for ADL self-care deficit related to her (R41's) dementia. Further, the care plan identified R41 required extensive assistance of 1 with ADL's and was to receive a tub bath once a week as requested by R41. In addition, the care plan noted R41 was to be provided a sponge bath, when a full bath could not be tolerated.

During an interview with R41 on 12/05/16, at 12:41 p.m. R41 stated she had not received weekly scheduled bath on a "regular basis " and was concerned because she required assistance from facility staff with her ADL's.

R41's Body Audit Form identified R41 had 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 indication that R41 had rejected ADL's with bathing 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 565	Continued From page 3	2 565		

unaware of R41 refusing a bath in the past, but was a "tough one" to bathe.

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 according to her care plan. Further RN-D stated R41's baths,"were not happening "according to the body audit forms.

During interview on 12/07/16, at 11:26 a.m. with director of nursing (DON) stated she was aware residents in the facility were not receiving their baths as directed by the care plan.

INCONTINENCE
R94's Admission Record undated indicated she had dementia and neurological disease. A facility Continence Evaluation form dated 12/06/16, indicated she was incontinent of bladder, onset was unknown, unable to sit on the toileted and was not motivated to toilet.

R94's Individual Resident Care Plan (temporary care plan) dated 12/1/16, indicated she was incontinent of bowel and bladder and toilet on rounds (every two hours). The care plan indicated R94 was high risk for falls, was unable to reposition herself.

R94's nursing assistant care sheet, undated, instructed staff to toilet the resident every two hours.

During continuous observation on 12/07/16, from 6:00 a.m. to 8:34 a.m. (2 hours and 34 minutes) R94 was lying in her bed on her right side with her nightgown on. There was no staff for R94 observed during this time. A 7:52 a.m. nursing

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2 565	Continued From page 4	2 565		

assistant (NA)-E looked into R94's room and walked by. At 8:13 a.m. NA-E entered R94's room stated he was checking on R94, but did not provide R94 with any cares. At 8:34 a.m. NA-E re-entered the room and removed R94's pad which was moderately soaked with urine, and had a small bowel movement. R94's entire peri- area was red and excoriated (damage or remove part of the surface of the skin). NA-E stated her bottom was very red, and applied peri cream to the area. NA-E stated he started at 6:00 a.m. and this was the first time during his shift he had provided cares to R94. NA-E said he did not know when R94 was last changed.

During interview 12/07/16, at 1:10 p.m. registered nurse (RN)-C stated R94 was incontinent of urine and should be toileted every two hours according to her care plan.

FALL INTERVENTIONS
R87's admission Minimum Data Set (MDS), dated 10/4/16, identified R87 was mildly, cognitively impaired, used a wheelchair for locomotion, and was at risk for falls and dependent upon staff for activities of daily living.

R87's care plan, dated 11/8/16 identified R87 at high risk for falls and included interventions for "Dycem non-slip material to remain in wheelchair at all times while resident is up in chair." R87's care plan did not direct staff to fasten the wedge cushion to the wheelchair.

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 the evening meal at 4:48 p.m., R87 was again observed seated in his wheelchair, and no Dye was present in the wheelchair. During

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	00614	A. BUILDING: ___ B. WING ___	C 12/08/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 5 observation on 12/8/16, at 9:09 a.m. R87 was seated in his wheelchair during breakfast, and no Dycem was observed in R87's wheelchair. During interview on 12/8/16, at 9:16 a.m. nursing assistant (NA)-F stated R87 did not have any Dycem in his wheelchair. NA-F stated she was unaware of dycem being a fall intervention, or was needed in R87's wheel chair. During interview on 12/8/16 at 11:13 a.m., the director of nursing (DON) stated fall interventions were communicated to staff daily at morning meetings. The DON further stated staff were expected to remember the interventions, and be implementing them. A policy regarding implementation of resident care plans was requested, but not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could inservice staff about implementing the care plan and then audit cares to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the	2 570		1/17/17

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2 570	Continued From page 6 participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to update the resident plan of care for falls with new interventions after a reassessment was completed for 1 of 2 residents (R92) reviewed for falls. Findings include: R92's diagnoses, as identified on the face sheet dated 12/8/16, included chronic respiratory failure, anxiety disorder and weakness. R92's admission Minimum Data Set (MDS) dated 11/22/16 indicated moderately impaired cognition. The care area assessment (CAA) for falls dated 11/22/16 identified R92 was at risk for falls due to shortness of breath with activity, unsteady gait and balance. The CAA also indicated R92 was working with therapy for strengthening and endurance, was making progress, and staff were to assist with mobility and transfers. During observation on 12/06/16 at 2:22 p.m., R92 was seated in her wheel chair just outside her room door. R92 wore shoes and socks, had oxygen tubing to the right of the wheel chair, with a nasal cannula in place. Clipped to her shirt was a cord, which lead directly to a TABS (a personal, movement-detecting safety) alarm, fastened to the back of the wheel chair. Review of an Investigation Report dated 11/22/16	2 570	Completed	

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indicated R92 had an unwitnessed fall in her room on 11/20/16. The interdisciplinary team added an intervention to place a TABS (a personal, movement-detecting safety) alarm for R92 when in wheel chair or in bed.

The care plan, revised 11/21/16, identified R92 was at high risk for falls, and directed staff to: anticipate and meet resident's needs; be sure the call light is within reach and encourage to use; encourage resident to participate in activities that promote exercise for strengthening; ensure resident is wearing appropriate footwear; follow fall protocol; and PT (physical therapy) evaluate and treat. R92's care plan lacked the TABS alarm intervention.

Review of the nursing aide care sheets, undated, identified R92 required stand by assist, was a moderate fall risk, was to bet toiled every 2 hours, and had a regular diet. The sheet did not include R92's fall intervention to use the TABS alarm.

During an interview on 12/8/16 at 10:02 a.m., nursing assistant (NA)-I stated she always carried and used her nursing sheet. After reviewing the sheet, NA-I said there was nothing about R92's alarm, "but I know [R92] is supposed to have the alarm on." NA-I stated she learns of changes to residents care plans at the change of shift meetings, but it would be important to know the care plan, especially 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 care plan in the resident's chart should have been updated, as well as the aide cares sheets. The DON stated the unit managers were responsible, and it was a matter of getting that task "completed and updated."

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2 570	Continued From page 8 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 provide 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.	2 570		
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:	2 800		1/17/17

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Based on observation, interview and document review, the facility failed to provide sufficient nursing staff to meet assessed resident needs for 4 of 5 residents (R41, R49, R94 and R87) reviewed for activities of daily living, 1 of 3 residents (R94) reviewed for pressure ulcers, and for 4 of 4 residents (R3, R50, R80, R20) and 10 of 10 staff members (NA-A, NA-C, NA-B, TMA-A, NA-D, LPN-C, SM-A, SM-B, SM-B, RN-A) who voiced concerns with the lack of sufficient nursing staff in the facility.

Completed

Findings include:

ASSESSED RESIDENT NEEDS NOT BEING MET:

See F282: The facility failed to ensure the plan of care was implemented for 4 of 5 residents (R41, R49, R94 and R87) reviewed who were dependent on staff for activities of daily living (ADLs).

See F312: The facility failed to provide baths and timely toileting assistance for 2 of 3 residents (R41, R94) reviewed that were dependent upon staff for activities of daily living (ADLs).

See F314: The facility failed to provide timely assistance for toileting and repositioning to reduce the risk of pressure ulcer development for 1 of 3 residents (R94) identified at risk of pressure ulcers.

RESIDENT CONCERNS WITH LACK OF STAFFING:

R3's quarterly Minimum Data Set (MDS) dated 8/23/16, identified R3 had intact cognition and

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required extensive assistance with ADLs.

During interview on 12/5/16, at 3:12 p.m. R3 stated the facility lacked sufficient nursing staff to meet her needs timely. R3 stated the nursing staff were getting, "Sloppy on cares," because they had to rush through them due to not having enough staff. R3 stated she was incontinent of urine that same day because she didn't get help with toileting quickly enough adding it made her feel, "Upset and furious."

R3's Device Activity Report dated 11/24/16 to 12/8/16, identified the following call light response times:
- On 11/25/16, at 11:27 a.m. the call light was on for 22 minutes and 17 seconds;
- On 11/25/16, at 1:46 a.m. the call light was on for 43 minutes and 35 seconds;
- On 11/27/16, at 1:00 p.m. the call light was on for 18 minutes and 15 seconds;
- On 11/28/16, at 7:58 a.m. the call light was on for 16 minutes and 25 seconds;
- On 11/30/16, at 11:39 a.m. the call light was on for 15 minutes and 14 seconds;
- On 11/30/16, at 6:52 p.m. the call light was on for 21 minutes and 8 seconds;
- On 12/2/16, at 8:37 a.m. the call light was on for 59 minutes and 20 seconds and;
- On 12/2/16, at 12:35 a.m. the bathroom call light was on for 47 minutes and 45 seconds.

R50's quarterly MDS dated 9/20/16, identified R50 had intact cognition and required extensive assistance with his activities of daily living (ADLs).

During interview on 12/5/16, at 2:10 p.m. R50 stated the facility needed more staff to completed resident care. R50 stated he needs help to use

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the bathroom and, at times, has come, "Pretty close" to having incontinence because there is not enough staff to assist him promptly.

R50's Device Activity Report dated 11/24/16 to 12/8/16, identified the following call light response times:
- On 11/30/16, at 2:01 a.m. the call light was on for 23 minutes and 32 seconds;
- On 11/30/16, at 11:42 a.m. the call light was on for 19 minutes and 28 seconds;
- On 12/7/16, at 3:03 a.m. the call light was on for 16 minutes and 32 seconds and;
- On 12/7/16, at 7:13 a.m. the call light was on for 20 minutes and 41 seconds.

R80's annual MDS dated 11/15/16, identified R80 had intact cognition and required extensive assistance with ADLs.

During interview on 12/5/16, at 2:30 p.m. R80 stated the facility was not adequately staffed. R80 stated she had waited up to 30 minutes for assistance before and at times just has to, "Hang on," to her bladder so she doesn't have incontinence.

R80's Device Activity Report dated 11/24/16 to 12/8/16, identified the following call light response times:
- On 11/30/16, at 6:52 p.m. the call light was on for 22 minutes and 7 seconds;
- On 12/7/16, at 7:10 a.m. the call light was on for 18 minutes and 41 seconds and;
- On 12/7/16, at 11:36 a.m. the call light was on for 16 minutes and 54 seconds.

R20's quarterly Minimum Data Set (MDS) dated

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10/6/16, identified R20 had moderate cognitive impairment.

During interview on 12/5/16, at 6:11 p.m. R20 stated the facility did not have enough staff to provide timely assistance with his needs. R20 stated he often has to wait up to 15 minutes for help, even after already asking for assistance. Further, R20 stated he had fallen in the hallway before and it took several minutes before staff responded to help him.

STAFF CONCERNS WITH LACK OF STAFFING:

During interview on 12/6/16, at 2:06 p.m. nursing assistant (NA)-A stated the facility is typically short staffed, "A couple times a week," and residents become upset their cares are not completed in a timely manner adding, "They [residents] can sense it." NA-A stated the resident baths are not always completed if they are short staffed and staff run around the facility, "Like chickens with their heads cut off," trying to get cares completed.

When interviewed on 12/6/16, at 2:28 p.m. NA-C stated the nursing staff was, "Really short," some days and being full staffed with four aides on the main unit of the facility was not consistently happening anymore adding, "We're lucky if we get four aides." NA-C stated it was difficult to complete all of the assigned cares for residents, like bathing, because of the lack of staffing. NA-C stated the residents, "Get really upset," when their baths and cares aren't completed. Further, NA-C stated several staff had reported the concerns with lack of sufficient staff to the nurse managers and administration of the facility, however, staff are just told, "We're working on it."

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During interview on 12/6/16, at 2:45 p.m. NA-B stated the memory care unit is typically staff with just two NA staff and a cart nurse. NA-B stated the memory care unit used to be staffed with three NA staff though, however, it was changed because administration felt people were just, "Standing around down here." NA-B stated two NA staff was not enough to care for the residents adequately or safely, "You need to have three aides because of the behaviors we have." NA-B stated resident care was suffering as a result of the lack of sufficient staffing adding, "They're [resident] not getting bathed," consistently. Further, NA-B stated these concerns regarding the lack of staff had been, "Voiced strongly," to managers and administration.

When interviewed on 12/6/16, at 3:22 p.m. trained medication aide (TMA)-A stated the facility typically would only staff, "The bare minimum of what we need," and cares were suffering as a result. TMA-A stated the facility was short staffed, "At least twice a week," and residents had been complaining about their baths and other cares not being completed.

During interview on 12/7/16, at 4:03 p.m. NA-D stated the memory care unit was supposed to be staffed with three NA staff and a cart nurse. NA-D stated if they did not have full staffing for the day, then cares suffer and were, "Not that good." Further, NA-D stated residents' range of motion and bathing was not always completed if they were short staffed adding, "Sometimes you can get it, sometimes you can't."

When interviewed on 12/7/16, at 4:47 p.m. licensed practical nurse (LPN)-C stated several residents had voiced concerns about a lack of

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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, "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 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 number of NA staff and, "RN/LPN/TMA" staff to have provide care for each shift. The chart identified the following desired staffing levels for a facility census of 70 (as it was during the survey):

- 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 AM shift: 3.5 - 3.6
- Nurse/TMA for PM shift: 3.5 - 3.6
- Nurse/TMA for night shift: 2.0

During an anonymous interview on 12/7/16, a staff member (SM)-A stated the facility was short staffed and baths, "Usually don't get done," as a result. Further, SM-A stated residents had voiced concerns to them about the lack of staff in the

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facility adding these complaints were heard, "A few times a week."

During an anonymous interview on 12/7/16, SM-B stated the staff end up working short staffed a, "Couple times a week," which results in call lights being answered slower and cares not being provided consistently. SM-B stated the facility used to have pool staff available which was helpful because, "At least [you] had that person there," to help with cares. SM-B stated the staff report these concerns to the nurses, but are just told, "Try to do your best." Further, SM-B stated they were unaware of anything being done by administration to handle or address the lack of staffing in the facility.

During another anonymous interview on 12/8/16, SM-C stated the facility administration had restructured the facility staffing a couple months prior and each unit should have at least two aides working. In addition, two bath aides were being 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

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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, however, added she didn't feel there was enough of a concern to justify changing the staffing levels in the facility. Further, the administrator stated the facility was looking at moving to a primary care nursing model and staffing would be adjusted to reflect this.

A facility Nursing Department Staffing policy dated 12/2010, identified an objective, "To provide adequate staffing for the nursing floor," and directed staff to use daily check in sheets to assign scheduled nursing staff to work groups, and attempt to replace a call in if one occurs.

SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could review current and ongoing staffing patterns to evaluate if addition or relocation of staff is needed to ensure all resident cares needs are met.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

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2 830	Continued From page 17	2 830		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate supervision, and interventions were implemented to prevent accident hazards for 4 of 5 residents (R87, R49, R75, R37) reviewed for accidents. In addition, the facility failed to ensure bed rails were properly fastened and secured to the bed frame to promote safety for 1 of 20 residents (R3) who had loose bed rails. Findings include: FALLS R87's admission Minimum Data Set (MDS), dated 10/4/16, identified R87 was cognitively impaired, used a wheelchair for locomotion, and was at risk for falls. R87's admission Care Area Assessment (CAA), dated 10/10/16, identified R87 was at risk for falls	2 830	Completed	1/17/17

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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 the evening meal at 4:48 p.m., R87 was again observed seated in his wheelchair, and no dycem was present in the wheelchair. During observation on 12/8/16, at 9:09 a.m. R87 was seated in his wheelchair during breakfast, and no dycem was observed in R87's wheelchair.

During interview 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.,

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registered nurse (RN)-C stated R87 no longer needed the dycem in his wheelchair once R87 received the new wheelchair cushion, which provided a non slip surface. RN-C stated the care plan had not been revised to discontinue the dycem.

During interview on 12/8/16, at 10:02 a.m. occupational therapist (OT)-A stated R87 needed the dycem in his wheelchair, and his wheelchair cushion did not provide an appropriate non slip surface.

During interview on 12/8/16 at 11:13 a.m., the director of nursing (DON) stated fall interventions were communicated to staff daily at morning meetings. The DON further stated staff were expected to remember the interventions, and be implementing them.

A facility policy titled "Fall Prevention," dated 9/1/16, directed all new admissions to the facility would be assessed for fall risk. The fall interventions on the care plan and assessment were to be implemented.

COFFEE BURN
R49's quarterly MDS dated 10/15/16, indicated R49 was severely cognitively impaired, and needed supervision and set up with eating.

A Progress Note dated 7/27/16, at 11:34 a.m. indicated R49 had picked up the coffee cup, was moving cup to her mouth spilled the hot coffee on left arm and lap. Reddened area appeared on left arm approximately "5' (inches) by 2", lap was reddened area on left leg 8" by 4", right leg 7" by 3".

A Risk Management report dated 7/27/16,

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indicated "Client was sitting at table in dinning room for breakfast. Client was given beverages prior to getting meal. While client was waiting for breakfast client grabbed the cup, moved it toward her mouth and accidentally spilled her coffee on her left arm and lap." Writer placed intervention in place for staff to fill coffee/hot liquid containers half full and add ice cubes to cool to room temp prior to serving, signage placed in front of the coffee carafes in east kitchen to remind staff of intervention.

R49's care plan dated 08/10/16, indicated "This resident required a mechanical soft diet and cueing by staff to eat. Cut up food as needed, coffee fill cup half-full and cool with ice prior to placing at the table, coffee should be luke-warm."

During observation 12/07/2016, at 12:34 p.m., nursing assistant (NA)-G provided R49 with her lunch tray along with a cup of coffee 3/4 full. There was no ice in the coffee, and steam was observed coming from the top of the coffee cup.

During interview on 12/07/16, at 12:40 p.m. NA-G stated she was not aware of any interventions they provide to keep R49's coffee luke warm.

During interview on 12/07/16, at 2:22 p.m., registered nurse (RN)-B stated R49's coffee should be luke warm by adding water. RN-B then stated R49's care plan indicated ice should be placed in her cup to keep it luke warm, not water. RN-B thought that intervention for R49 had changed.

RESIDENT TO RESIDENT ALTERCATION
R75's quarterly Minimum Data Set (MDS) dated 11/5/16, indicated she was severely cognitively

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impaired and depressed.

R75's care plan dated 09/29/16, indicated she had a behavior of repeatedly asking for certain staff, related to dementia with behavior disturbance. The care plan directed staff to assist R75 to develop more appropriate methods of coping and interacting, and to encourage R75 to express feelings appropriately.

R37's quarterly MDS dated 11/1/16, indicated she was severely, cognitively impaired and had diagnoses which included dementia.

A progress note dated 10/12/16 at 3:58 p.m. indicated R75 was observed to hover over another resident (R37). The note indicated staff instructed R75 to stay away from the other resident's personal space, because R37 was agitated. R75 walked over and gave R37 a left sided upper body hug. R37 swung their right fist and hit R75 in the head. There were no apparent injuries. R75 was again advised to go to her room if she couldn't keep to herself. R75 did go to her room and no further behaviors were identified.

An Incident Report dated 10/13/16, indicated that on 10/12/16, in the afternoon staff had noted R75 standing near R37, showing concern for her. Staff offered R75 reassurance and asked her to give R37 some personal space as R37 displayed some agitation towards others at this time. R37 was in Broda chair (tilting and reclining wheelchair) and R75 was ambulating using her walker. She preceded to walk up to R37 and gave her a left sided hug. R37 then proceeded to make a fist with her right hand and strike R75.

Although staff offered reassurance to R75 before

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the altercation with R37. There was no change with interventions implemented for either resident, after R37 struck R75, to help reduce the risk of resident to resident altercations and keep both residents safe.

LOOSE SIDE RAILS
R3's quarterly Minimum Data Set (MDS) dated 8/11/16 identified R3 was cognitively intact and required extensive assistance with activities of daily living (ADL's). R3 had a diagnosis of severe morbid obesity and generalized muscle weakness.

During observation on 12/05/16, at 3:10 p.m. R3's bed was fitted with bilateral, quarter side rails, approximately 24" (inches) in length and 8" in height. The rails were fastened to bed frame, with a screw. When grasped, each rail could be moved back and forth approximately 2" from the bed frame.

During interview on 12/05/16, at 3:19 p.m. with registered nurse (RN)-E stated (R3's) side rails felt "very loose" and was a safety risk for R3. Further, RN-E stated R3 frequently used the side rails to assist her in sitting up in bed.

When interviewed on 12/05/16, at 3:22 p.m. R3 stated the side rails had always been "very loose" and were difficult to use when they were that loose.

During interview on 12/05/16, at 6:53 p.m. the registered nurse (RN)-A stated R3's side rails felt "wobbly" which placed the resident at risk for falls and may become an entrapment risk if the side rails became any looser.

On 12/08/16, at 1:03 p.m. MS stated the usual

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2 830	Continued From page 23 facility practice was for facility staff to notify maintenance with concerns with paper slips. Further, MS stated there was no system in place for side rail maintenance. Review of policy titled, "Side Rails" dated 6/11/16 identified staff members are to assess the side rail is safe, provide education to residents and are utilized within manufacture's instructions. SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could review and reeducate all staff on the policies and procedures to ensure that all residents at risk for accidents were reassessed, interventions implemented and properly supervisor to prevent accident hazards. The director of nursing or her designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 835	MN Rule 4658.0520 Subp. 2 A Adequate and Proper Nursing Care; Criteria Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: Evidence of adequate care and kind and considerate treatment at all times. Privacy must be respected and safeguarded. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide baths and	2 835	Completed	1/17/17

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timely toileting assistance for 2 of 3 residents (R41, R94) reviewed that were dependent upon staff for activities of daily living (ADLs).

Findings include:

R41's quarterly Minimum Data Set (MDS) dated 11/21/16, identified R41 was moderately cognitively impaired and required total assistance for ADL's. In addition, R41 had no rejection of ADL's during the MDS assessment period.

R41's plan of care dated 10/06/16, noted R41 had an identified problem for ADL self-care deficit related to her (R41's) dementia. Further, the care plan identified R41 required an extensive assistance of one with ADL's and was to receive a tub bath once a week as requested by R41. In addition, the care plan noted R41 was to be provided a sponge bath when a full bath could not be tolerated.

During an interview with R41 on 12/05/16, at 12:41 p.m. R41 stated she had not received weekly scheduled baths on a "regular basis "and was concerned because she required assistance from facility staff for her ADL's.

R41's Body Audit Form identified R41 had 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

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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 bowel and bladder and was toileted on rounds. An untitled and undated nursing assistant care sheet, identified R94 was to be toileted every two hours.

A Continence Evaluation assessment dated 12/06/16, indicated R94 was incontinent of bladder and wore a brief. The assessment further indicted it was unknown if R94 had an urge to void and did not use the toilet.

During continuous observation on 12/07/16, from 6:00 a.m. to 8:34 a.m. (2 hours and 34 minutes) R94 was lying in her bed on her right side with

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2 835	Continued From page 26	2 835		
	her nightgown on. There was no staff for R94 observed during this time. A 7:52 a.m. nursing assistant (NA)-E looked into R94's room and walked by. At 8:13 a.m. NA-E entered R94's room stated he was checking on R94, but did not provide R94 any cares. At 8:34 a.m. NA-E re-entered the room and removed R94's pad which was moderately soaked with urine, and had a small bowel movement. R94's entire peri- area was red and excoriated (damage or remove part of the surface of the skin). NA-E stated her bottom was very red, and applied peri cream to the area. NA-E stated he started at 6:00 a.m. and this was the first time during his shift he had provided cares to R94. NA-E said he did not know when R94 was last changed.			
	During interview 12/07/16, at 1:10 p.m. RN-C stated R94 was incontinent of urine. RN-C reported (R94) was dependent upon staff and at risk for skin breakdown, and should be checked and changed every two hours.			
	SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service staff responsible for meeting bathing and toileting for residents. The facility could develop a monitoring system to ensure ongoing compliance and report the findings to the Qualify Assurance Committee.			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers	2 900		1/17/17

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2 900	Continued From page 27 Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide timely assistance for toileting and repositioning to reduce the risk of pressure ulcer development for 1 of 3 residents (R94) identified at risk of pressure ulcers. Findings include: R94's undated Admission Record indicated R94 was admitted on 12/01/16, which included diagnoses of dementia and multiple sclerosis (A disease in which the immune system eats away at the protective covering of nerves). R94's admission Minimum Data Set (MDS) was not completed. A Braden Skin assessment (scale for predicting pressure ulcer risk) dated 12/01/16, indicated R94 had occasionally moist skin, was bed fast,	2 900	Completed	

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had very limited mobility, with a potential problem of friction and shear. The assessment had a score of 14 which indicated R94 was at moderate risk for developing a pressure ulcer.

R94's Individual Resident Care Plan (temporary care plan) dated 12/1/16, indicated R94 was incontinent of bowel and bladder and was to be toileted on rounds. R94's care plan did not indicate she was at risk for pressure ulcers.

During continuous observation on 12/07/16, from 6:00 a.m. to 8:34 a.m. (2 hours and 34 minutes) R94 was lying in her bed on her right side with her nightgown on. There was no staff for R94 observed during this time. At 7:52 a.m. nursing assistant (NA)-E looked into R94's room and walked by. At 8:13 a.m. NA-E entered R94's room and said he was checking on R94, but did not provide R94 any cares. At 8:34 a.m. NA-E re-entered the room and removed R94's pad which was moderately soaked with urine, and had a small bowel movement. R94's entire peri- area was red and excoriated (damage or remove part of the surface of the skin). NA-E stated her bottom was very red, and applied peri cream to the area. NA-E stated he started at 6:00 a.m. and this was the first time during his shift he had provided cares to R94. NA-E said he did not know when R94 was last changed.

During interview 12/07/16, at 1:10 p.m. registered nurse (RN)-C stated R94 was incontinent of urine, and at risk for skin breakdown. She should be checked/changed every two hours and repositioned during this time.

A facility policy "Prevention and Treatment of Skin Breakdown." reviewed 3/2016, directed staff to "Properly identify and assess residents who's

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2 900	Continued From page 29 clinical conditions increase the risk for impaired skin integrity, and pressure ulcers, to implement preventative measures, and to provide appropriate treatment modalities for wounds according standards of care." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could inservice staff regarding implementation of a care plan to ensure appropriate treatment of pressure ulcers, and then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by:	2 910		1/17/17

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(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) COMPLETE DATE
2 910	Continued From page 30 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 Findings include: R38's admission Minimum Data Set (MDS) dated 08/04/16, indicated R38 was always continent of urine. The quarterly MDS dated 10/31/16, indicated R38 was frequently incontinent of urine (7 or more episodes of incontinence but at least one episode of continence). The care area assessment (CAA) dated 8/10/16, identified R38 was on a diuretic (reduces fluid), and needed assistance with toileting. Further, the CAA identified R38 did not always ask for assistance due to cognitive impairment, and staff were to toilet R38 every two hours. R38's care plan dated 08/09/16, indicated he required extensive assistance of one for toileting. A Bladder 7 Day Documentation from 7/28/16 thru 8/4/16, indicated R38 was never incontinent of urine. A subsequent bladder assessment from 10/26/16 thru 11/1/16, indicated R38 was incontinent of urine nine times, which was a change in status from his previous assessment in August 2016. The quarterly bladder assessment dated 11/1/16 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.	2 910	Completed	

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2 910	Continued From page 31	2 910		

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 1:45 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. 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 possible.

SUGGESTED METHOD OF CORRECTION:
The director of nursing or designee, could review all residents who needed assistnace with toileting, to assure they are receiving the necessary treatment/services to prevent potential decline in toileting. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented.

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2 910	Continued From page 32 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		
2 960	MN Rule 4658.0600 Subp. 1 Dietary Service - Food Quality Subpart 1. Food quality. Food must have taste, aroma, and appearance that encourages resident consumption of food. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure prepared foods were flavorful when served for 1 of 1 residents (R69) who complained about poor tasting food. This had potential to affect 10 of 10 residents identified by the facility as having received the meal. Findings include: R69's quarterly Minimum Data Set (MDS) dated 10/22/16, identified R69 had moderate cognitive impairment. During observation of the Rosewood Unit evening meal service on 12/5/16, at 6:18 p.m. dietary aide (DA)-A wheeled a mobile cart into the kitchenette to begin serving the meal. DA-A placed a metallic serving pan into the steam table which contained a loaf of sliced white bread with only its top crusts exposed. DA-A began to plate food by removing single pieces of bread from the pan and placing them on several different plates to be served. The bread sagged downward as DA-A removed it from the pan with only the top portion of crust on each piece having visible yellowing coloring or	2 960	Completed	1/17/17

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2 960	Continued From page 33	2 960		

seasoning. DA-A served plates with this bread on it to several residents along with pizza and salad.

When DA-A finished serving resident trays, a sample tray was requested by the surveyor. The bread was not toasted, but rather soft and limp, with only visible yellow seasoning on the top crust. The surveyor tasted the bread and it lacked any garlic flavor.

When interviewed on 12/5/16, at 6:55 p.m. DA-A stated the white bread was supposed to be garlic toast, however, "Just the top of the bread" appeared to have any seasoning or coloring adding, "I think it could use a little bit more garlic." Further, DA-A stated she served the bread to approximately ten residents during the meal service.

When interviewed on 12/5/16, at 6:56 p.m. R69 stated the garlic bread served for the evening meal lacked flavor and was not very good, "I've tasted better."

During interview on 12/7/16, at 3:28 p.m. the dietary director (DD) stated the cook had prepared the garlic toast incorrectly adding she, "Didn't like the way it looked" when it was served. DD stated the cook should have laid each piece out and buttered it separately to, "Get more butter on the bread and more flavor."

A facility supplied Garlic Bread Recipe Preparation dated 12/7/16, directed cooking staff to, "Brush melted margarine on each slice of bread," for serving.

An undated facility Residents' Rights and Responsibilities Related to Food Service Operations policy, undated, identified residents

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2 960	Continued From page 34 should be served, "...nourishing, palatable, and well-balanced meals that meet daily nutrition and special needs." SUGGESTED METHOD OF CORRECTION: The dietitian and food service director could ensure policies and procedures are accurate and address food palatability. Appropriate staff could be trained. Audits could be conducted and residents randomly interviewed for satisfaction. The results of the audits could be brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 960		
21235	MN Rule 4658.0700 Subp. 2 C Medical Director;Develop standard of Practice Subp. 2. Duties. The medical director, in conjunction with the administrator and the director of nursing services, must be responsible for: C. the development of standards of practice for medical care to provide guidance to attending physicians; This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to collaborate with the medical director to address concerns of physician continuity for 1 of 1 residents (R31) who did not receive medical care under a consistent physician. Findings include:	21235	Completed	1/17/17

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R31's admission minimum data set (MDS), dated 8/26/16, indicated no cognitive impairment.

R31's hospital discharge report, dated 8/19/16, indicated she had been admitted to the facility following a hospital stay related to leg pain, which also indicated a follow up appointment with her primary physician at the facility in one week. R31's diagnosis list, dated 12/7/16, further identified an admission diagnosis of cellulitis (skin infection) along with a history of diabetes with nephropathy (kidney damage), heart failure, and chronic obstructive pulmonary disease.

A review of physician and physician assistant (PA) notes identified the following:

On 8/31/16, R31 received a visit and was assessed by her primary medical doctor (MD-B). The note indicated that R31 needed monthly visits due to her "Advanced multiple comorbid conditions with multiple medications" and that "Given long-term placement in skilled nursing facility will need to transfer care."

On 10/17/16, 47 days after her last physician visit, R31 had an appointment to establish care with a different physician, MD-C outside the facility who assessed R31. The note identified MD-C would be contacting the facility to "Clarify the issue concerning R31's non-eligibility for in-facility care." On 10/24/16, MD-C declined to take R31 as a patient recommending an Internal Medicine Provider, and offered to place referral for the facility.

On 11/3/16, 76 days after her admission, R31 had an appointment with a PA-A. After assessing R31, the PA-A also declined to take R31 as a

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patient due to her complex medical history and recommended an Internal Medicine Physician.

On 11/18/16, 91 days after she was admitted, R31 had an appointment with a MD-D outside the facility who completed an assessment of R31 and became her primary physician.

A facility Progress Note, dated 9/26/16, indicated the facility had requested the facility's Medical Director (MD)-A to follow R31 starting 9/27/16, because they were unable to find a physician for R31. A Progress Note, dated 10/26/16, indicated the facility Medical Director-A had declined to follow R31 as a patient.

R31's medical record lacked any indication the Medical Director-A had completed an assessment of R31 in September, when R31 was not seen within 30 days of her last physician assessment. There was also no indication the Medical Director-A had been contacted to assist R31 to establish care with a primary physician.

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. R31 stated she hadn't been seen by the Medical Director, but had been told he couldn't follow her due to age and insurance. R31 stated since the facility's Medical Director wouldn't see her, she "was hanging again" and was "Just hoping and praying things got better."

During interview on 12/7/16, at 5:29 p.m. MD-A stated he wasn't able to take R31 as a patient due to her younger age. He further stated he hadn't seen R31 in person in September, just reviewed her chart and thought she was already

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21235	Continued From page 37 referred to another physician. The MD-A was unaware R31 had not been assessed by a physician in September or that she was denied care twice. The MD-A would have expected the facility to contact him when R31 was denied care stating he was ultimately responsible for her care. During interview on 12/8/16, at 11:03 a.m. director of nursing (DON) stated MD-A should have been involved in finding care for R31 since he had refused to follow her as her primary physician. The facility's Medical Director Agreement, reviewed 1/29/16, identified the responsibilities to include the "Overall coordination of medical care in the facility to ensure the adequacy and appropriateness of the medical services provided to residents." SUGGESTED METHOD OF CORRECTION: The Medical Director or designee could develop, review, and/or revise policies and procedures to ensure appropriate resident care and services are being provided by physicians. The Medical Director designee could educate all appropriate staff on the policies and procedures. The Medical Director or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: 30 DAYS	21235		
21290	MN Rule 4658.0710 Subp. 3 A AdmissionOrders & Physician Evaluations Subp. 3. Frequency of physician evaluations. A. A resident must be evaluated by a physician at least once every 30 days for the first 90 days after admission, and then whenever	21290		1/17/17

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21290	Continued From page 38 medically necessary. A physician visit is considered timely if it occurs within ten days after the date the visit was required. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure that physician visits were provided at least once every 30 days for the first 90 days after admission for 1 of 5 residents (R31) who were newly admitted to the facility. Findings include: R31's admission minimum data set (MDS), dated 8/26/16, indicated no cognitive impairment. R31's hospital discharge report, dated 8/19/16, indicated she had been admitted to the facility following a hospital stay related to leg pain. R31's diagnosis list, dated 12/7/16, identified an admission diagnoses of cellulitis (skin infection) along with a history of diabetes with nephropathy (kidney damage), heart failure, and chronic obstructive pulmonary disease. A review of physician and physician assistant (PA) notes identified the following: - On 8/31/16, R31 received a visit and was assessed by her from her primary physician. The note indicated that R31 needed monthly visits due to her "Advanced multiple co-morbid conditions with multiple medications" and that "Given long-term placement in skilled nursing facility will need to transfer care."	21290	Completed	

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- 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 would stop seeing a patient when admitted 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 ultimately

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21290	Continued From page 40 responsible for overseeing R31's care. A facility copy of the Combined Federal and States Bill of Rights, dated 11/28/16, directed the facility would seek alternate physician services to "Assure provision of appropriate and adequate care and treatment." Suggested Method of Correction: The director of nursing (DON) or designee could work with the medical director and administrator to ensure physician coverage is provided the residents in the facility. The administrator, DON or designee could also perform audits of resident records to determine if the physician services had been provided. Time Period for Correction: Twenty-one (21) days.	21290		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and	21390		1/17/17

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21390	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 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: SEPTEMBER 2016: An Order Listing Report dated 12/5/16, identified four different residents had received antibiotics	21390	Completed	

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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 Services reports dated 9/1/16, through 9/30/16, identified different cultures of collected specimens. The reports identified three different residents had urine samples cultured with the same bacteria, however lacked any information on the date of symptom onset, resolution, or if the infection was determined to be community or in-house acquired.

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.

OCTOBER 2016:

An Order Listing Report dated 12/5/16, identified six residents had received antibiotics during the month for different diagnosis which included chronic pain syndrome, pneumonia, yeast, and severe sepsis. The report lacked any dates of symptom onset or resolve, organism cultures, room numbers, or if the infection was determined to be community or in-house acquired.

An undated Infection Report Form identified a

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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 spreading in the facility.

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There was no further information provided for any of the identified months of data.

When interviewed on 12/7/16, at 3:36 p.m. the director of nursing (DON) stated the person who had been in charge of the program was no longer employed at the facility and they were in the process of being reassigned to someone else to oversee. Further, the DON stated the infection control program lacked consistent monitoring, trending or analysis of the collected data adding, "We have to come to a better system," and, "Have better tracking of that [infections in the facility]." Further, the DON stated she had been aware the program was lacking these components for the past couple weeks.

During interview on 12/8/16, at 10:32 a.m. the administrator stated staff were, "Always watching" for infections during their regular meetings throughout the week, however do not start any processes for tracking or trending unless patterns of infection are being noted, "I look for the pattern."

A facility Infection Control Program policy dated 2/16/16, identified an objective which included, "Help prevent the development and transmission of disease and infection." The policy identified several elements of the facility program which included, "Surveillance based on systemic data collection," and having, "A system for detection, investigation, and control of outbreaks of infectious disease." Further, the policy identified summaries of the infections were to be compiled and analyzed by the infection control committee, with findings being communicated to determine if changes in practice or procedures were required.

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21390	Continued From page 45 HAND HYGIENE R39's admission Minimum Data Set (MDS) dated 7/12/16, identified R39 was cognitively intact with a diagnosis of congestive heart failure and an right above the knee amputation. On 10/17/16, R39's significant change in status MDS identified R39 had an unstageable pressure ulcer on R39's left heel and another on his coccyx. R39's treatment administration record identified a physician order on 11/04/16, for "Dressing change to left heel: Clean open area with normal saline, dry. Cover with Melgisorb dressing. Change daily and on an as needed basis." During observation on 12/07/16, licensed practical nurse (LPN)-A donned a set of clean gloves. With her clean gloves, LPN-A took off the soiled bandage from R39's left heel and threw it in the trash. Without first removing her soiled gloves, LPN-A-A obtained a new bandage and accidentally dropped it on the floor. She grabbed the bandage off the floor and obtained a pen from her (LPN-A's) pocket to mark a date on the dressing without first removing her soiled gloves. With her same soiled gloves, LPN-A irrigated R39's left heel pressure ulcer. After irrigating R39's left heel, R39 placed his clean heel unto the soiled bed linen. With her same soiled gloves, she placed a new clean dressing over R39's left heel and then removed her soiled gloves. LPN-A than proceeded to wash her hands in R39's bathroom. When interviewed on 12/07/16, at 7:33 a.m. licensed practical nurse (LPN)-A stated she contaminated the pressure ulcer on R39's left heel after she (LPN-A) touched the ground and dug in her pocket with her gloved hands. LPN-A stated R39's heel should have not touched the bed after being irrigated because it increased	21390		

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21390	Continued From page 46 R39's risk for an infection. Further, LPN-A stated it is important to don on a clean set of gloves when working with pressure ulcers because there was a higher risk of "contaminating " the area and an increased risk of infection. During interview on 12/07/16, at 11:18 a.m. the assistant director of nursing (ADON)-A stated wearing dirty gloves could contaminate the area and increased the risk of infection to R39's pressure ulcer on his left heel. When interviewed on 12/07/16, at 11:43 a.m. the director of nursing stated it was "inappropriate " to wear soiled gloves during pressure ulcer treatment as it could increase the risk of infection to the pressure ulcer on R39's left heel. A policy regarding hand hygiene was requested, but not provided during the survey. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review their infection control program to ensure policies and procedures are established, inservice staff regarding policy and procedure, and audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		
21475	MN Rule 4658.1005 Subp. 1 Social Services: General Requirements Subpart 1. General requirements. A nursing home must have an organized social services department or program to provide medically related social services to each resident. A nursing home must make referrals to or	21475		1/17/17

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21475	Continued From page 47 collaborate with outside resources for a resident who is in need of additional mental health, substance abuse, or financial services. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide the necessary social services to assist residents in finding a physician for 1 of 1 residents (R31) who did not have a primary physician. Findings include: R31's admission minimum data set (MDS), dated 8/26/16, indicated no cognitive impairment. R31's hospital discharge report, dated 8/19/16, indicated she had been admitted to the facility following a hospital stay related to leg pain, which also indicated a follow up appointment with her primary physician at the facility in one week. R31's diagnosis list, dated 12/7/16, further identified an admission diagnosis of cellulitis (skin infection) along with a history of diabetes with nephropathy (kidney damage), heart failure, and chronic obstructive pulmonary disease. Review of physician and physician assistant (PA) notes identified the following: On 8/31/16, R31 received a visit and was assessed by her primary medical doctor (MD-B). The note indicated that R31 needed monthly visits due to her "Advanced multiple comorbid conditions with multiple medications" and that "Given long-term placement in skilled nursing facility will need to transfer care."	21475	Completed	

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On 10/17/16, 47 days after her last physician visit, R31 had an appointment to establish care with a different physician, MD-C outside the facility who assessed R31. The note identified MD-C would be contacting the facility to "Clarify the issue concerning R31's non-eligibility for in-facility care." On 10/24/16, MD-C declined to take R31 as a patient recommending an Internal Medicine Provider, and offered to place referral for the facility.

On 11/3/16, 76 days after her admission, R31 had an appointment with a PA-A. After assessing R31, the PA-A also declined to take R31 as a patient due to her complex medical history and recommended an Internal Medicine Physician.

On 11/18/16, 91 days after she was admitted, R31 had an appointment with a MD-D outside the facility who completed an assessment of R31 and became her primary physician.

R31's medical record lacked any indication social services was involved in assisting R31 to establish care with a primary physician while a resident at the nursing the facility.

During interview on 12/7/16, at 5:29 p.m. medical director (MD)-A stated he was unaware R31 was not assessed by a physician in September or that she had subsequently been denied care twice. MD-A stated it was the responsibility of R31's primary physician to continue care until a replacement physician was found. However, after R31 was denied care from her primary physician, he would have expected the facility's social services to aide in finding R31 an appropriate physician.

During interview on 12/8/16, at 11:03 a.m. social

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21475	Continued From page 49 worker (SW)-A stated residents were typically followed by their primary physician, unlike R31's situation. SW-A stated she thought the nursing staff were working on finding R31 a new physician and social services did not have any role in assisting R31 to find a physician. SUGGESTED METHOD OF CORRECTION: The social worker or designee, could review and/or revise facility policies and procedures related to medically related social services. Responsible personnel could be re-educated on these policies and procedures. Appropriate efforts could be made toward supporting the social service needs of the individual(s) identified in the deficiency, with supporting documentation maintained. Other residents could be evaluated for social service needs. An auditing system could be developed and implemented, with results shared with the facility's Quality Assessment & Assurance committee, to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21475		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being	21540		1/17/17

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21540	Continued From page 50 adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on interview, and document review, the facility failed to ensure non-pharmacological interventions and behavior monitoring were completed prior to administering anti-anxiety medications for 1 of 5 residents (R80) reviewed for unnecessary medications. Findings include: R80's quarterly Minimum Data Set (MDS) dated 08/11/16, indicated R80 had no cognitive impairment with a diagnosis of major depressive and anxiety disorder. R80's Care Area Assessment (CAA) dated 11/15/16, noted R80 had no behaviors or psychosis and required extensive assistance of one with activities of daily living (ADL's). R80's care plan dated 02/23/16, indicated R80 had an identified problem of, "Resident uses anti-anxiety medications [Ativan] related to anxiety disorder." Interventions for R80 included; monitor/record occurrence for behaviors	21540	Completed	

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symptoms and document per facility protocol. There was no indication of how R80's exhibited her anxiety.

During observation on 12/6/16 between 1:45 p.m. to 2:28 p.m. R80 exhibited no outward signs of anxiety. During observation on 12/7/16 from 6:00 a.m. to 8:30 a.m., R80 presented no signs of anxiety.

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.

In September 2016, R80 took her as needed lorazepam on 10 different occasions. During the above episodes no signs of anxiety, or non-pharmacological interventions were attempted prior to the use of the medication.

In October 2016, R80 received 7 doses of lorazepam, and signs of anxiety, or non-pharmacological interventions were attempted prior to the use of the medication. There was no indication of why the medication was being given.

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In November 2016, R80 took 6 doses of lorazepam and signs of anxiety, or non-pharmacological interventions were attempted prior to the administration of the medication.

Review of R80's pharmacist drug regimen review on 01/20/16, the consultant pharmacist (CP) indicated facility staff needed to document behaviors, non-pharmacological approaches attempted and effectiveness for R80's as needed lorazepam. On 11/14/16, the CP again indicated the documentation on R80's lorazepam needed to include behaviors and non-pharmacological interventions.

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.

When interviewed on 12/07/16, the director of nursing (DON) stated it was important for facility staff to document non-pharmacological interventions and behaviors "to evaluate" the effectiveness of the as needed lorazepam. There is no rational for the use of this medication at the current dose for R80.

Review of an undated facility policy titled, "Psychotropic Medication Use Guidelines", identified all anti-anxiety medication administered to residents required facility staff to " quantitatively and objectively" document behaviors symptoms.

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21540	Continued From page 53 A SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures to ensure that residents do not receive unnecessary medications, ensure all medications include parameters, and educate all relevant staff. The DON or designee can develop monitoring systems to ensure ongoing compliance and report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21540		
21550	MN Rule 4658.1325 Subp. 1 Adminiatration of Medications; Pharmacy Serv. Subpart 1. Pharmacy services. A nursing home must arrange for the provision of pharmacy services. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure tuberculin solution was available for resident and staff use and were not expired. This had potential to affect 3 of 9 residents (R94, R93 and R98) who received the expired solution. In addition, the facility failed to ensure medications were given according to manufactures instructions for 1 of 1 residents (R94). Findings include: EXPIRED TUBERCULIN SOLUTION On 12/05/16, at 05:10 p.m. the West medication	21550	Completed	1/17/17

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storage room was observed with registered nurse (RN)-D. The West medication storage refrigerator contained an opened package of Tuberculin Purified Protein Derivative (TB) (a medication used to test for exposure to Tuberculosis) with an expiration date of 10/10/16, written on the vial. RN-D stated the tuberculin solution was available for residents and facility staff. Further, RN-D stated expired TB solution should not be administered after the expiration date because it could cause an "inaccurate result."

Upon review of documentation titled, "Baseline TB Screening for nursing home and boarding residents" R94 was given an expired TB test (lot number 772984) on 12/1/16, 21 days after it expired. R93 was given expired TB solution (lot number 772984) on 11/22/16, 12 days after it expired and R98 was administered TB test (lot number 772984) on 11/21/16, 11 days after it expired.

On 12/05/16, at 05:36 p.m. the Rosewood medication storage room was observed with assistant director of nursing RN-A. A refrigerator inside the medication room contained an opened package of Tuberculin Purified Protein Derivative with no expiration date written on the vial. RN-A stated the tuberculin solution was available for residents. Further, RN-A stated the TB solution should have been discarded after 30 days from being opened and they had no way of knowing when the solution was opened.

During interview on 12/06/16, at 8:49 a.m. director of nursing (DON) stated the tuberculin solution should have been discarded after being opened for thirty days because the medications effectiveness could be decreased.

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A facility policy on expiration dates for TB solution was requested, but was not provided during the survey.

MANUFACTURE GUIDELINES:
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 of the mouth.

R94's Dismissal Summary from Mayo Clinic dated 12/1/16, indicated R94 had dysphagia (difficulty swallowing) and had a peg (percutaneous endoscopic gastrostomy, which is placed in abdominal wall and stomach to allow nutrition, fluids and/or medications to put directly into the stomach, bypassing the mouth and esophagus) tube placed. Further, R94 was to receive myrbetriq (medication for treatment of overactive bladder) 25 milligrams (mg) sustained release (designed to release medication in body over a extended period of time) by mouth every morning.

A speech therapy (ST) Plan Of Care, dated 12/02/16, indicated R94 was unable to swallow on command and had no spontaneous swallow noted.

During observation 12/07/16, at 10:40 a.m. listened practical nurse (LPN)- D set up R94's medications. LPN-A crushed all of R94's medications except for THE myrbetriq. LPN-D stated the medication was "sustained released" and could not be crushed, and was ordered to be given by mouth. LPN-D entered R94's room and

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administered R94's medications, except myrbetriq, via peg tube. LPN-A then stated she would not be able to give R94 myrbetriq because she was uncertain if R94 could swallow the pill.

During interview 12/07/16, at 1:00 p.m. LPN-D stated she spoke with R94's physician who discontinued myrbetriq. LPN-D also stated R94 had received the myrbetriq five times since admission, but was uncertain how the staff administered this medication to R94.

During interview 12/08/16, at 9:15 a.m. the director of nursing (DON) stated the staff must have been giving the myrbetriq by crushing it, and administering it via the peg tube. The DON stated the nurses should have clarified this order with R94's physician.

During a subsequent interview on 12/08/16, at 9:21 a.m. LPN-D stated she had given R94 myrbetriq by crushing it and giving it via R94's peg tube.

A facility policy was requested on giving medications according to manufacture specifications and was not received.

A Patient Information from the manufacture Astellas Pharma US, Inc. revised August 2016, instructed patients "You should take Mybetriq with water and swallow the tablet whole. Do not crush or chew the tablet".

SUGGESTED METHOD OF CORRECTION:
The director of nursing and or pharmacist can educate all staff responsible for medication storage to remove outdated medications to prevent unwanted use by resident/s, and ensure medication is provided according to manufacture

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21550	Continued From page 57 recommendations. The DON or designee can develop monitoring systems to ensure ongoing compliance and report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21550		
21705	MN Rule 4658.1415 Subp. 6 Plant Housekeeping, Operation, & Maintenance Subp. 6. Heating, air conditioning, and ventilation. A nursing home must operate and maintain the mechanical systems to provide comfortable and safe temperatures, air changes, and humidity levels. Temperatures in all resident areas must be maintained according to items A to C: A. For construction of a new physical plant, a nursing home must maintain a temperature range of 71 degrees Fahrenheit to 81 degrees Fahrenheit at all times. B. For existing facilities, a nursing home must maintain a minimum temperature of 71 degrees Fahrenheit during the heating season. C. Variations of the temperatures required by items A and B are allowed if the variations are based on documented resident preferences. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide housekeeping and maintenance services necessary to maintain comfortable temperatures 2 of 5 resident rooms (R162, R165) and one or three resident dayrooms reviewed in the facility, which had the potential to affect 50 residents who used these	21705	Completed	1/17/17

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21705	Continued From page 58	21705		

areas.

Findings include:

During observation on 12/08/16, at 12:47 p.m. an environmental tour of the facility was conducted with maintenance supervisor (MS) who confirmed the following findings:

The resident dayroom, located off of the main dining room, was cool. The temperature measured at 66 degrees Fahrenheit (F).

In R162, the temperature in the room measured at 70 degrees F.

In R167 the temperature in the room measured at 66 degrees F.

On 12/08/16, at 1:03 p.m. MS confirmed all of the findings listed above. MS stated the usual facility practice was for facility staff to notify maintenance with concerns with paper slips, which were picked up in the morning and as needed by the maintenance staff. Further, MS stated he had not checked resident or common area room temperatures in over a month because he did not "have time," and was working on getting around to it.

A policy on facility maintenance was requested, but was not provided during the survey.

Suggested Method of Correction: The director of facility operations (DOF) operations or designee could work with the administrator to update policies and procedures for when to regulate heat for the resident rooms, and ensure a process to monitor resident room temperatures. The DON or designee could perform audits of resident

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21705	Continued From page 59 rooms to determine if the temperature is adequate. Time Period for Correction: Fourteen (14) days.	21705		
21800	MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults.	21800		1/17/17

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21800	Continued From page 60 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide the appropriate liability notice to 2 of 6 residents (R64 and R91) reviewed who were discharged from Medicare services. Findings include: R64's admission Minimum Data Set (MDS), dated 10/28/16, indicated he received physical and occupation therapy while admitted in the facility. R64's was provided and signed a Notice of Medicare Non-Coverage CMS 10095 (which explains a resident's right to an immediate appeal through the QIO or Quality Improvement Organization on 11/4/16, identifying his Medicare services where ending on 11/7/16. R64 was discharged from the facility on 11/8/16. R64's received notice form CMS 10095, which identified Straits Health as the QIO. R64 should have received the form CMS 10123, and not the CMS 10095, which was the incorrect form. R91's admission MDS, dated 11/18/16, indicated he received physical and occupation therapy while a resident in the facility. R91 was a current resident at the facility. R91 received and signed liability notice form CMS 10095 on 11/22/16, regarding Medicare services ending on 11/24/16. Since R91 remained in the facility, he also received the a SNF determination on continued stay (which explains a resident's financial obligations when Medicare services end). R91 should have received the form CMS 10123, and not the CMS 10095, which was the incorrect form.	21800	Completed	

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21800	Continued From page 61	21800		

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 CMS 10095 form, expired 10/31/2013, over three years ago.

SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop, review, and/or revise policies and procedures to ensure staff are educated on the appropriate liability notices to provide residents at the end of Medicare services, and to ensure resident rights are communicated appropriately and acted upon. The administrator or designee could educate all appropriate staff on the policies and procedures and develop a monitoring systems to ensure ongoing compliance.

TIME PERIOD FOR CORRECTION: Twenty-one (21) Days

21855	MN St. Statute 144.651 Subd. 15 Patients & Residents of HC Fac.Bill of Rights	21855		1/17/17

Subd. 15. Treatment privacy. Patients and

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residents shall have the right to respectfulness and privacy as it relates to their medical and personal care program. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discreetly. Privacy shall be respected during toileting, bathing, and other activities of personal hygiene, except as needed for patient or resident safety or assistance.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and document review, the facility failed to ensure personal privacy was provided by staff for 1 of 5 residents (R94) who were dependent upon staff for activities of daily living.

Completed

Findings include:

R94's Admission Record, undated, indicated R94 had dementia and a neurological disease. The individual Resident Care Plan dated 12/1/16, indicated R94 needed staff assistance with dressing, bathing and grooming.

During observation 12/05/16, at 7:09 p.m. R94 was lying in bed with her sheets pulled down. R94 was lying on her left side, with her hospital gown completely open in the back, exposing her bare back and buttocks with an incontinent product. R94's door was completely open to the hallway, as staff and visitors walked past. Numerous staff were observed walking by R94's room, but made no attempts to assist R94 to cover herself or close the door to maintain R94's privacy.

During interview on 12/05/16, 7:20 p.m. licensed

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21855	Continued From page 63 practical nurse (LPN)-A stated R94 "fidgets around" and must have pulled off her sheets. LPN-A stated (R94) should not have been left uncovered for others to see. During observation 12/06/16, at 7:55 a.m., R94 was lying in bed, with the room door completely open, exposing her back side. R94 wore an incontinent product, which had fallen down and exposed the top of her buttocks. Staff walked by R94's room, and an unidentified nurse was administering medication from the cart parked just outside of R94's room. Staff made no attempts to cover R94, or close her door to ensure R94's personal privacy. During interview 12/08/16, at 9:31 a.m. the director of nursing (DON), stated staff should have provided privacy and attempted to keep R94 covered. The DON stated the facility will be working on educating the staff on privacy. A policy was requested for privacy and was not provided. SUGGESTED METHOD OF CORRECTION: The Director of Nursing Services or designee could develop, review, and/or revise policies and procedures to ensure all residents' privacy is maintained. The Director of Nursing Services or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing Services or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21855		

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21870	Continued From page 64	21870		
21870	MN St. Statute 144.651 Subd. 18 Patients & Residents of HC Fac.Bill of Rights Subd. 18. Responsive service. Patients and residents shall have the right to a prompt and reasonable response to their questions and requests. This MN Requirement is not met as evidenced by: Based on interview, and document review, the facility failed to address a resident council request to have the administrator or DON present during council meetings, which had the potential to affect 6 of 6 residents (R13, R65, R6, R53, R48 and R30) who attended council meetings. Findings include: R13's quarterly Minimum Data Set (MDS) dated 9/11/16, identified intact cognition. The MDS also indicated R13 was usually understood when expressing ideas and could make her needs known. R65's quarterly MDS dated 11/19/16, indicated cognitive impairment. The MDS also indicated R65 was understood when expressing ideas and could make her needs known. R6's quarterly MDS dated 10/25/16, indicated intact cognition. The MDS also indicated R6 was understood when expressing ideas and could make his needs known. R53's quarterly MDS dated 9/6/12, indicated moderate cognition impairment. The MDS also indicated R53 was usually understood when expressing ideas and could make her needs	21870	Completed	1/17/17

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Continued From page 65

known.

R48's quarterly MDS dated 11/19/16, indicated cognitive impairment. The MDS also indicated R48 was understood when expressing ideas and could make her needs known.

R30's quarterly MDS dated 9/3/16 indicated intact cognition. The MDS also indicated R30 was understood when expressing ideas and could make her needs known.

During interview on 12/6/16, at 3:23 p.m. R13 stated she attended the resident council meetings. During the September meeting, there was a suggestion made to have the administrator or the DON (director of nursing) present at the meetings. R13 stated it was "frustrating" not having management there, and would be nice just to have their presence. R13 stated she would like them partake in the meeting process, and added they wouldn't have to stay the whole time. R13 stated it would be nice "just to hear us guys out." R13 could not recall seeing the DON or the administrator present at either the September or October resident council meeting.

Resident council meeting minutes from June, July, August, September and October 2016 were reviewed. The minutes dated Friday September 16, 2016 indicated under new business, "Residents expressed that they would like to have the administrator, director of nursing and possibly dietary attend meetings on a periodic basis in order for them to hear concerns and give suggestions for improvement or change."

A review of the council meeting minutes dated October 21, 2016, indicated the residents

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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 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

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21870	Continued From page 67 also stated it would not be difficult for either the administrator, the DON, or other staff to be at the meetings. Further, SW stated at the next resident council meeting, administration should be present to discuss how often they should come. The SW stated there were no resident council meetings held in November. During interview on 12/7/16, at 3:57 p.m., the director of nursing (DON) stated she was not informed of the council's request, nor received the council meeting minutes to read about their request. The DON thought she had to be "invited" to the council meeting. Further,the DON stated she is always talking with residents on the units, on a daily basis, and that this would be another way for residents, and staff, to talk about what their needs are. A facility policy, "Resident Council", revised 5/23/2014, indicated its objective "...to promote a sense of belonging and community decision making among the residents," and would "...provide residents with the opportunity to air any grievances that hey may have and to give suggestion on what they would like." The policy further indicated grievances aided during the meeting should be "addressed within the proper department," and that any follow-up can be addressed "at the next Resident Council Meeting." SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing or designee could provide staff education relating to policy and procedure for resident grievance and resolution. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21870		

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21942	MN St. Statute 144A.10 Subd. 8b Establish Resident and Family Councils Resident advisory council. Each nursing home or boarding care home shall establish a resident advisory council and a family council, unless fewer than three persons express an interest in participating. If one or both councils do not function, the nursing home or boarding care home shall document its attempts to establish the council or councils at least once each calendar year. This subdivision does not alter the rights of residents and families provided by section 144.651, subdivision 27. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to establish a family council for the nursing facility this had the potential to affect all 70 residents who resided in the facility. Findings include: A review of documents provided to the survey team indicated the facility attempted to establish a family council. A letter invited people to a "Family Interest Group" whose purpose was "...to give family and friends a voice in decisions that affect their loved ones..." The letter, undated, indicate a meeting date of May 13, 2015, along with agenda items. In an interview on 12/7/16 at 4:04 p.m., the facility administrator said the the family council was discussed on a call to the facility's management in early November. The administrator also said the interdisciplinary team	21942	Completed	1/17/17

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21942	Continued From page 69 at the facility discussed, and decided, with the holidays coming up, to try to get a council going after the holiday season. The administrator stated we needed to get Talahi to a place where we are comfortable, and to that point, our efforts were best invested to bring the facility "up to compliance" and wit until after the holidays to make an attempt to re-establish the council. The administrator acknowledged no movement on the council since May of 2015. The administrator, denied putting the establishment of the council on the back burner, but insisted there were a lot of extenuating circumstances this past year. The administrator felt there was a better chances to establish the council after the holidays, and stated "It was not on the calendar this year." A review of a facility document "Outline for Weekly Admin (administration)/COO (chief operating officer) Call, dated 11/7/2016, indicated the words "family council" under the Admissions/Marketing section. The facility provided no further documentation regarding the establishment of a family council. SUGGESTED METHOD OF CORRECTION: The facility could send a letter out to all family members, and/or talk to all family members to see if a family council program can be developed. TIME PERIOD OF CORRECTION: Twenty (21) days	21942		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated,	21980		1/17/17

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or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless:

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

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

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

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00614	A. BUILDING: ______ B. WING ______	C 12/08/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21980	Continued From page 71	21980		

how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c.

This MN Requirement is not met as evidenced by:
Based on interview and document review, the facility failed to ensure allegations of abuse and injuries of unknown origin were immediately reported to the administrator and/or state agency (SA) and were thoroughly investigated for 2 of 5 residents (R97 and R33) whose allegations of abuse incidents were reviewed.

Completed

Findings include:

R97's significant change MDS dated 05/18/16, indicated she was severely, cognitively impaired and had no behaviors. R97's care plan dated 3/17/16, indicated she had diagnoses of altered mental status and depression.

A Risk Management Report, dated 6/9/16 at 10:20 a.m. indicated during a bath, R97 had a bruise on the top of her left hand that measured 6 centimeters (cm) by 4 cm, and was blue, with a 1 cm dark, purple area in the center. The report further indicated R97 had no complaints of pain and when asked if she bumped it, R97 smiled and nodded. There was no indication the administrator and state agency were immediately notified of the injury of known origin, nor was a thorough investigation completed to determine the possible cause of the injury.

During interview on 12/07/16, at 11:00 a.m. the administrator was unable to recall the incident.

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	00614	A. BUILDING: ______ B. WING ______	C **12/08/2016**

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

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She thought since R97 nodded her head and smiled after being asked if she bumped it, this was probably why the incident was not reported. The administrator then stated if the resident is cognitively impaired the report should have been reported immediately reported to her, SA and then investigated.

R33's quarterly MDS dated 09/06/16, indicated she was severely cognitively impaired. R33's care plan dated 03/02/15, indicated she had impaired thought processes and cognitive status, secondary to Alzheimer's disease, and had difficulty verbalizing needs.

A Incident Report dated 11/15/16, indicated nursing assistant (NA)-H reported to registered nurse (RN)-B that a possible abuse incident allegedly took place during the morning of 11/12/16, with an alleged perpetrator, whom was immediately suspended. NA-H reported she was rough while grabbing R33 by the forearms during morning cares on 11/12/16. R33 was examined, and two bruises were found on her left forearm, on the top of her arm measuring two cm by four cm; and one on the underside of her arm measuring 2 cm by 2 cm. There were also bruises located on R33's right forearm, measuring 2 cm by 4.5 cm, and the one on the underside measured 2 cm by 2.5 cm. The report indicated the incident was reported to the state agency on 11/15/16, three days after the incident occurred. There was no indication the administrator and state agency was immediately notified of the incident.

During interview 12/07/16, at 11:15 a.m. the facility administrator stated the incident "should have been" immediately reported to her and the

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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.

TIME PERIOD OF CORRECTION: Ten (10) days