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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: JGDH

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00614

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **06/01/2013**

6. DATE OF SURVEY **1/15/2014** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A1*** (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):
See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Nicolle Marx, HFE NE II — 01/03/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 02/06/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
02/11/2014
(L33)

DETERMINATION APPROVAL

Page 2

Provider Number: 24-5438

Item 16 Continuation for CMS-1539

Post Certification Revisit by review of the facility's plan of correction, to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Effective January 1, 2014, the facility is certified for 77 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245438

March 4, 2014

Mr. Raymond Dykhuizen, Administrator
Talahi Nursing And Rehab Center
1717 University Drive Southeast
Saint Cloud, Minnesota 56304

Dear Mr. Dykhuizen:

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 1, 2014, the above facility is certified for:

77 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245438	A. Building B. Wing	1/15/2014

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0166** Reg. # **483.10(f)(2)** LSC	Correction Completed **01/03/2014**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **01/01/2014**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **01/01/2014**
ID Prefix **F0242** Reg. # **483.15(b)** LSC	Correction Completed **01/01/2014**	ID Prefix **F0322** Reg. # **483.25(g)(2)** LSC	Correction Completed **01/01/2014**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **01/01/2014**
ID Prefix **F0353** Reg. # **483.30(a)** LSC	Correction Completed **01/01/2014**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **01/01/2014**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **01/01/2014**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	KJ/SG	3/4/14	31220	1/15/14
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
11/15/2013			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245438	A. Building / B. Wing: **01 - MAIN BUILDING 01**	1/2/2014

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix: Reg. # **NFPA 101** LSC K0050	**01/01/2014**	ID Prefix: Reg. # LSC		ID Prefix: Reg. # LSC	
ID Prefix: Reg. # LSC		ID Prefix: Reg. # LSC		ID Prefix: Reg. # LSC	
ID Prefix: Reg. # LSC		ID Prefix: Reg. # LSC		ID Prefix: Reg. # LSC	
ID Prefix: Reg. # LSC		ID Prefix: Reg. # LSC		ID Prefix: Reg. # LSC	
ID Prefix: Reg. # LSC		ID Prefix: Reg. # LSC		ID Prefix: Reg. # LSC	

Reviewed By State Agency	**Reviewed By** PS/KJ	**Date:** 3/4/2014	**Signature of Surveyor:** 27200	**Date:** 1/2/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 11/13/2013		**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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245438	A. Building B. Wing	11/18/2013

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0497** Reg. # **483.75(e)(8)** LSC	Correction Completed **11/18/2013**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	KL/AK	02/12/2014	30339	11/18/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:
10/9/2013

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

March 18, 2014

Mr. Raymond Dykhuizen, Administrator
Talahi Nursing and Rehabilitation Center
1717 University Drive Southeast
Saint Cloud, Minnesota 56304

RE: Project Numbers S5438025, H5438036, H5438037and H5438038

Dear Mr. Dykhuizen:

On October 31, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for an abbreviated standard survey, completed on October 9, 2013 that included an investigation of complaint number H5438037, found to be unsubstantiated and investigation of complaint number H5438038 found to be substantiated. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On November 15, 2013, the Minnesota Departments of Health and Public Safety completed a standard survey to verify that your facility had maintained compliance with federal certification requirements for skilled nursing facility and/or nursing facilities participating in the Medicare and/or Medicaid Programs. Based on our visit, we have determined that your facility has not achieved substantial compliance. The most serious deficiencies in your facility at the time of the standard survey were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), where by corrections are required.

As a result of the most recent survey findings and continuous noncompliance, this Department recommended to the CMS V office the following remedy; they concur and have authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective January 9, 2014. (42 CFR 488.417 (b))

In addition, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 9, 2014.

On January 15, 2014 and January 18, 2014 the Minnesota Department of Health, Licensing and Certification Program, and Office of Health Facility Complaints completed PCRs and on January 2, 2014, the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 9, 2013.

We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 1, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our abbreviated standard survey, completed on October 9, 2013 and our standard survey completed November 15, 2013, as of January 3, 2014.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of December 14, 2013. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective January 9, 2014, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective January 9, 2014, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective January 9, 2014, is to be rescinded.

In our letter of December 9, 2013, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 9, 2014, due to denial of payment for new admissions. Since your facility attained substantial compliance on January 3, 2014, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

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

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: JGDH

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00614

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **06/01/2013**

6. DATE OF SURVEY **11/15/2013** (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:
X 1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A1*** (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):
See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Mary Rogers, HFE NE II 01/03/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 02/06/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00000
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN-24-5438

At the time of the Standard survey, the facility was not in substantial compliance with Federal Certification Regulations. This survey found the most serious deficiencies in your facility to widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), Post Certification Revisit to follow. Please refer to the CMS 2567 along with the facility's plan of correction.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7009 1410 0000 2304 1233

December 9, 2013

Mr. Raymond Dykhuizen, Administrator
Talahi Nursing And Rehab Center
1717 University Drive Southeast
Saint Cloud, Minnesota 56304

RE: Project Number S5438025, H5438037and H5438038

Dear Mr. Dykhuizen:

On October 31, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for an abbreviated standard survey, completed on October 9, 2013 that included an investigation of complaint number H5438037, found to be unsubstantiated and investigation of complaint number H5438038 found to be substantiated. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On November 15, 2013, the Minnesota Departments of Health and Public Safety completed a standard survey to verify that your facility had maintained compliance with federal certification requirements for skilled nursing facility and/or nursing facilities participating in the Medicare and/or Medicaid Programs. Based on our visit, we have determined that your facility has not achieved substantial compliance. The most serious deficiencies in your faclity at the time of the standard survey were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopartdy (Level F), where by corrections are required.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. As a result we are recommending the following remedy to the CMS Region V Office imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective January 9, 2014. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective January 9, 2014. They will also notify the State Medicaid Ageny that they must also deny payment for new Medicaid admissions effective January 9, 2014. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Talahi Nursing And Rehab Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective January 9, 2014. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

A copy of the Statement of deficiencies (CMS 2567) for both health and life safety code pursuant to the standard survey completed on November 15, 201 are enclosed.

APPEAL RIGHTS

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 9, 2014 (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.

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;

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

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

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

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

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

DEPARTMENT CONTACT

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

Sarah Grebenc, Unit Supervisor
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557

Phone: (320) 223-7365
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 November 18, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by November 18, 2013 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 January 9, 2014 (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 April 9, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5438s14_OHFC&LCCertLtr.rtf

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 _____	11/15/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an 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. A complaint investigation had been completed at the time of the standard recertification survey. Investigations of complaint H5438038 had been completed and had been substantiated. Deficiencies had been issued as a result of the substantiated findings at F166. An investigation of complaint H5438037 had not been substantiated during this survey.	F 000	RECEIVED DEC 20 2013 MN Dept of Health St.Cloud	
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to seek resolution to an outside provider's verbalized complaint to facility staff, related to untimely administration of pain medication and a missing pain medication patch;	F 166	F166 Right to Prompt Efforts to Resolve Grievances Facility failed to seek resolution to an outside providers verbalized complaint to facility staff, related to untimely administration of pain medication and a missing pain medication patch. The facility also failed to acknowledge a resident's (R44) verbalized request for a private room. Resident (R44) was placed on a private room waiting list, and resident was moved to a private room on 12/4/13.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Raymond Dyckhuizen | TITLE: ADMINISTRATOR | (X6) DATE: 12/20/13

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 166	Continued From page 1 for 1 of 5 residents (R71) reviewed for pain. The facility also failed to acknowledge a resident's verbalized request for a private room, for 1 of 1 resident (R44) reviewed for admission, transfer and discharge. Findings include: R71's hospice provider complained that licensed practical nurse (LPN)-E demonstrated an untimely response to the provider's request that she administer an as needed (PRN) pain medication on the evening of 10/18/13. The hospice provider also expressed concern regarding a Fentanyl patch (medicated patch for pain relief) that was thought to have been missing on the evening of 10/18/13. Review of R71's Diagnosis/History form dated 2/6/13, revealed diagnoses including dementia and chronic pain. His signed physician orders dated 10/2/13, included the following: Morphine sulfate 100 milligrams (mg)/ five milliliters (ml) of solution, 0.5 ml (10 mg) was to be administered sublingually (underneath the tongue) every half hour PRN for shortness of breath or pain; Fentanyl 50 micrograms (mcg)/ one hour patch, one transdermal (applied to the skin) patch was to be administered every 72 hours for chronic pain and placement of the patch was to be checked every shift. A daily progress note for R71 written by hospice registered nurse (HRN) on 10/21/13, at 9:38 a.m. revealed, "Writer reviewed with [registered nurse (RN)-A, R71's nurse manager] the concerns that were brought forth this weekend with volunteer vigil and [hospice social worker (HSW)]. Writer will continue to monitor facility staff for	F 166	Staff were educated on 11-20-13 on the grievance policy and the formal grievance form residents and/or families may use to record their concerns or complaints. Staff not able to attend will be given a makeup packet or educated at mini-inservices held during regularly scheduled shifts. To ensure continued timely resolution of concerns staff are completing Resident Interviews weekly to audit resident concerns/preferences at least quarterly to ensure timely resolution of concerns. Residents will be audited at time of care conference on room preference. Facility DON held conversation with outside provider on 11-21-13 to ensure improved communication occurred with complaints. Facility staff were educated on the Pain Management Policy on 12-19-13. Staff were educated on 11-20-13 on the Grievance Policy and the formal grievance form residents and/or families may use to record their concerns or complaints. Staff not able to attend will be given a makeup packet or educated at mini-inservices held during regularly scheduled shifts. Residents will be reminded of formal complaint form at each care conference, to ensure residents are	

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F 166	Continued From page 2 appropriateness of care. [RN-A] expressed her concern with weekend staff and will follow-up with individual staff from previous weekend." During interview on 11/14/13, at 9:35 a.m. HRN indicated that his above note referenced concerns reported to him by the provider's social worker, of untimely administration of R71's PRN pain medication by LPN-E and a Fentanyl patch that was missing during HSW's visit over the prior weekend. HRN verified that he relayed these concerns to RN-A. He added that he did not know what follow-up occurred from their conversation, other than to state that he believed RN-A had spoken to LPN-E about the concern. During a telephone interview on 11/14/13, at 1:20 p.m. HSW reported that on the evening of 10/18/13, she sat vigil with R71. HSW explained, in his dying process, R71 was non-verbal and facial grimacing was the only way he communicated pain. HSW reported she observed facial grimacing on R71 and requested the nurse on duty, LPN-E administer his PRN pain medication at approximately 8:00 p.m. HSW indicated LPN-E responded, "I'll be right there ... I'm busy." HSW reported she received the same response several times when she repeatedly tried to seek LPN-E out, to administer R71's PRN pain medication. She added she was told earlier in her visit that R71's Fentanyl patch was missing. She was informed the facility staff had already searched the bed and R71's person, but did not find it. Per HSW's report, at approximately 10:00 p.m., facility staff approached R71 to again search his bed and body for the Fentanyl patch. Since such a search would have required manipulation of R71's position, HSW refused to allow the search, until the PRN pain medication	F 166	aware of process. Employee handbook was reviewed regarding Disciplinary Procedures and actions to take regarding concerns with employees, or concerns brought forward by outside providers, and what may require additional actions and training. Social services director monitors complaint form box daily and documents that it was checked to ensure complaints are addressed timely. The DON will summarize the findings of audits and present them to the unit managers, and to the QA committee for further recommendations and changes. Completion Date: January 1,2014	1-1-14

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F 166	Continued From page 3 was administered and given time to take effect. HSW reported that the PRN pain medication was administered at approximately 10:15 p.m. and she remained with R71 until approximately 10:45 p.m. to ensure he was not moved until his pain had subsided. HSW revealed that she left the facility prior to the staff searching for the Fentanyl patch and wanted to confirm whether the patch was found or verify appropriate actions were taken if not found. During interview on 11/14/13, at 2:06 p.m. RN-A reported she did not recall a conversation with HRN regarding the above noted concerns. She indicated she was unaware of any concerns of untimely medication administration and was unaware of a Fentanyl patch that was thought to be missing for R71. RN-A verified she did not follow-up on these concerns as she did not recall them having been reported to her. During interview on 11/15/13, at 9:00 a.m. director of nursing (DON) confirmed she was unaware of the above noted concerns. DON reported that RN-A should have contacted her about the hospice provider's concern and re-educated LPN-E. During a follow-up interview at 12:30 p.m., the DON reported the facility had received only one formal, written grievance during the past survey period. She added that facility management encouraged staff, residents and families to verbalize their concerns directly to the pertinent manager and that manager was then expected to forward concerns to herself or the facility administrator, rather than directing concerns through the facility's formal grievance process. The DON did acknowledge that in some circumstances, documenting and/or maintaining evidence of the facility's response to verbalized	F 166		

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F 166	Continued From page 4 complaints might have ensured the appropriate actions were taken to resolve a grievance. R44 requested a private room upon her admission to the facility, but the facility failed to effectively act on her request. Review of R44's physician orders dated 11/15/13, revealed diagnoses including osteoporosis, pelvic fracture, insomnia, anxiety and depression. R44 was admitted to the facility in 12/12. The quarterly Minimum Data Set (MDS) dated 9/11/13, revealed R44 was independent with making decisions regarding tasks of daily life. During interview on 11/12/13, at 1:52 p.m. R44 complained that she had been on a waiting list for a private room since her admission to the facility, but when a room became available several weeks prior, it was given to another resident who had not been in the facility as long as she had. R44 reported that privacy was very important to her and having her own room was a "big concern" of hers. She reported that she felt she would have slept better and healed quicker if she had her own, private room. R44 added that RN-B (her nurse manager) was "fighting" on her behalf to fulfill her request for a private room, "but it hasn't helped." During interview on 11/14/13, at 11:19 a.m. RN-B verified R44 had requested a private room when she was first admitted into the facility. She added that due to a history of difficulties with prior roommates, R44 was "supposed to have one." RN-B reported that she forwarded R44's wishes for a private room to social services (SS)-A and activities (A)-A during "stand-up meetings." RN-B	F 166		

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F 166	Continued From page 5 reported that to her knowledge, R44 was on the facility's waiting list for private rooms. RN-B verified knowledge of other residents having received private rooms ahead of R44, but was unsure why. Review of Referrals/ Private Room/ On or Off Rosewood form, undated, lacked R44's request for a private room. During interview on 11/14/13, at 11:24 a.m. A-A verified she and SS-A were responsible for maintaining a waiting list for room change and private room requests. She reported a written waiting list was initiated only one month prior. A-A confirmed to her knowledge, R44 had not requested a private room and was not on the waiting list. A-A reported she was unaware of the facility's process for maintaining such a waiting list prior to one month ago, when she and SS-A took over responsibility for private room requests. During interview on 11/14/13, at 11:45 a.m. SS-A reported that she started working at the facility in 7/13, and was unaware as to the facility's process for tracking resident requests for private room requests. She reported that to her knowledge, the Review of Referrals/ Private Room/ On or Off Rosewood form included all residents who had requests for room changes and/or private rooms. Upon discussion of R44 and RN-B's above interviews, SS-A verified, "Someone dropped the ball." The facility's Grievance Policy dated 9/24/13, noted, "Upon receiving an oral complaint, Social Services, or the appropriate supervisor, will interview all parties involved and take immediate action to remedy the complaint, if possible."	F 166		

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F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225	F225 Investigate/Report Allegations/Individuals Facility failed to ensure allegations of resident to resident altercations and an elopement were reported to the administrator and state agency immediately for 5 of 7 residents reviewed for abuse allegations. Staff were educated on November 20, 2013 on the Resident Protection Policy and Procedure for reporting vulnerable adult situations and what to report and when to report and whom to report to. Staff not able to attend will be given a makeup packet or educated at mini-inservices held during regularly scheduled shifts. VA Investigation Form was edited to clearly record administrators notification. DON or designee will audit 20 staff a week to ensure knowledge of reporting procedures. DON will summarize the findings of audits and present them to the QA committee for further recommendations and changes. Completion Date: January 1, 2014	1-1-14

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F 225	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of resident to resident altercations and an elopement were reported to the administrator and state agency (SA) immediately for 5 of 7 residents (R90, R69, R48, R82, and R55) reviewed for abuse allegations. Findings include: Resident to resident altercations were not reported immediately to the facility administrator and the state agency. Resident (R90)'s quarterly Minimum Data Set (MDS) dated 10/11/13, identified R90 had severe cognitive impairment and required assistance from one person for most activities of daily living (ADL)'s. R69's quarterly MDS dated 10/17/13, identified R69 had severe cognitive impairment and required assistance from two persons for most ADL's. Review of the facility's VA Investigation Packet, indicated on 10/30/13. at 1:15 p.m., R90 was sitting next to R69 when R90 stated, "she hit me right here " [pointing to her right upper arm.] R90 and R69 were separated after R90 reported the incident to nursing assistant (NA)-I. Reviewing the Investigative Report completed by the facility the incident was submitted to the state agency on 10/31/13 (one day after the incident occurred). Licensed practical nurse (LPN)-C was interviewed on on 11/14/13, at 11:22 a.m., and stated she was made aware of the incident involving R90 and R69 on 10/31/13, after the morning stand up meeting and then she reported it to the state agency. LPN-C verified that the incident should have been reported immediately on 10/30/13, by the charge nurse who worked	F 225		

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F 225	Continued From page 8 that shift. Although the facility was aware R90 and R69 had an altercation, the facility failed to ensure the administrator and state agency were notified immediately. R48 quarterly MDS dated 9/06/13, identified R48 had severe cognitive impairment and was independent with ambulation. R82 quarterly MDS dated 9/17/13, identified R82 had moderate cognitive impairment and required assistance from one person for most ADL's. Review of the facility's VA Investigation Packet, indicated on 9/17/13, R48 was standing over R82, who was sleeping in the recliner. R48 loudly told R82, "get up and go, I don't want you here. I will have you thrown out. This is my place." R48 was unable to get R82's attention and slapped his left arm. Reviewing the Investigative Report completed by the facility the incident was submitted to state agency on 9/20/13 (three days after the incident occurred.) During interview with social worker (SW) on 11/14/13, at 11:11 a.m., she verified the incident between R48 and R82 was not reported immediately to either the administrator and the state agency and was unsure of why it was not SW also stated her and the director of nursing (DON) often complete the state agency reports together. Although the facility was aware R48 and R82 had an altercation, the facility failed to ensure the administrator and state agency were notified immediately. Resident elopement incident was not reported immediately to the facility administrator and the state agency. R55 quarterly MDS dated 8/26/13, identified R55	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245438	A. BUILDING _____ B. WING _____	11/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 225	Continued From page 9 had moderate cognitive impairment and was independent with most ADL's. Review of the facility's VA Investigation Packet, indicated on 10/08/13, LPN-C observed R55 on the camera entering the door to the facility unattended. LPN-C escorted R55 back into the memory care unit and notified the cart nurse about R55 being outside. Reviewing the Investigative Report completed by the facility the incident was submitted to state agency on 10/16/13 (eight days after the incident occurred.) During interview with licensed practical nurse (LPN)-C on 11/14/13, at 11:22 a.m., stated she had reported off to the cart nurse on R55's unit and thought the cart nurse would complete the state agency report and LPN-C did not notify the DON or administrator. LPN-C also verified that after a morning stand up meeting on 10/16/13, it was noticed no state agency report was made regarding the incident and a report was made that day by her. Although the facility was aware of R55 elopement from the facility, the facility failed to ensure the administrator and state agency were notified immediately. During interview with the DON on 11/14/13, at 3:47 p.m., she stated facility staff are instructed to report any type of abuse, elopement, and financial exploitation to their supervisor immediately which then will contact the DON or the administrator and report it to the state agency. DON reviewed and verified each incident and should have been reported immediately to her and the administrator and the state agency. During interview with the administrator on 11/15/13, at 10:28 a.m., he stated the facility staff are to report to their supervisor, DON, SW and him any alleged abuse. The administrator then verified each incident and agreed he should have	F 225		

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F 225	Continued From page 10 been notified and the state agency immediately. According to the facility policy titled Resident Protection Policy and Procedure, last review date 09/24/13, indicated ...Notify the Administrator and the Director of Nursing of designees immediately of incident and to other officials in accordance with state law...All employees and volunteers are mandated to report maltreatment... report the information to the Supervisor immediately. The supervisor in turn will immediately report all suspected maltreatment to the Administrator, DON, Social Services Director and to other officials in accordance with state law. If you cannot report the information to your supervisor, you may call the Social Services Director or DON...A mandated reporter shall make a report to the state reporting agency immediately of alleged incident...	F 225		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement an abuse prohibition policy which requires immediate notification to the administrator and state agency on allegations of resident to resident altercations and an elopement for 5 of 7 residents (R90, R69, R48, R82, and R55) reviewed for abuse allegations. Findings include:	F 226	F226 Development/Implement Abuse/Neglect, etc. Policies Facility failed to implement an abuse prohibition policy which requires immediate notification of the administrator and state agency on allegations of resident to resident altercations and an elopement for 5 of 7 residents reviewed for abuse allegations. Staff were reeducated on 11-20-13 on the Resident Protection Policy and Procedure for reporting vulnerable adult situations and what to report and when to report and whom to report to.	

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F 226	Continued From page 11 According to the facility policy titled Resident Protection Policy and Procedure, last review date 09/24/13, indicated ...Notify the Administrator and the Director of Nursing of designees immediately of incident and to other officials in accordance with state law...All employees and volunteers are mandated to report maltreatment... report the information to the Supervisor immediately. The supervisor in turn will immediately report all suspected maltreatment to the Administrator, DON [director of nursing], Social Services Director and to other officials in accordance with state law. If you cannot report the information to your supervisor, you may call the Social Services Director or DON...A mandated reporter shall make a report to the state reporting agency immediately of alleged incident... During interview with the director of nursing (DON) on 11/14/13, at 3:47 p.m., she stated facility staff are instructed to report any type of abuse, elopement, and financial exploitation to their supervisor immediately which then will contact the DON or the administrator and report it to the state agency. During interview with the administrator on 11/15/13, at 10:28 a.m., he stated the facility staff are to report to their supervisor, DON, SW and him any alleged abuse. Although the policy identified the facility staff should report the incident to the administrator and Director of Nursing (DON), the facility failed to contact the administrator and state agency immediately. Resident (R90)'s quarterly Minimum Data Set (MDS) dated 10/11/13, identified R90 had severe cognitive impairment and required assistance from one person for most activities of daily living (ADL)'s. R69's quarterly MDS dated 10/17/13, identified	F 226	Staff not able to attend will be given a makeup packet or educated at mini-inservices held during regularly scheduled shifts. VA Investigation Form was edited to clearly record administrators notification per Policy. DON or designee will audit 20 staff a week to ensure staff are aware of reporting procedures and following the Policy. DON will summarize the findings of audits and present them to the QA committee for further recommendations and changes. Completion Date: January 1, 2014	1-1-14

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F 226	Continued From page 12 R69 had severe cognitive impairment and required assistance from two persons for most ADL's. Review of the facility's VA Investigation Packet, indicated on 10/30/13, at 1:15 p.m., R90 was sitting next to R69 when R90 stated, "she hit me right here" [pointing to her right upper arm.] R90 and R69 were separated after R90 reported the incident to nursing assistant (NA)-I. Reviewing the Investigative Report completed by the facility the incident was submitted to the state agency on 10/31/13 (one day after the incident occurred.) Licensed practical nurse (LPN)-C was interviewed on 11/14/13, at 11:22 a.m., and stated she was made aware of the incident involving R90 and R69 on 10/31/13 after the morning stand up meeting and then she reported it to the state agency. LPN-C verified that the incident should have been reported immediately on 10/30/13 by the charge nurse who worked that shift. Although the facility was aware R90 and R69 had an altercation, the facility failed to ensure the administrator and state agency were notified immediately. R48 quarterly MDS dated 9/06/13, identified R48 had severe cognitive impairment and was independent with ambulation. R82 quarterly MDS dated 9/17/13, identified R82 had moderate cognitive impairment and required assistance from one person for most ADL's. Review of the facility's VA Investigation Packet, indicated on 9/17/13, R48 was standing over R82, who was sleeping in the recliner. R48 loudly told R82, "get up and go, I don't want you here. I will have you thrown out. This is my place." R48 was unable to get R82's attention and slapped his left arm. Reviewing the Investigative Report completed by the facility the incident was	F 226		

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F 226	Continued From page 13 submitted to state agency on 9/20/13 (three days after the incident occurred.) During interview with social worker (SW) on 11/14/13, at 11:11 a.m., she verified the incident between R48 and R82 was not reported immediately to either the administrator and the state agency and was unsure of why it was not SW also stated her and the director of nursing (DON) often complete the state agency reports together. Although the facility was aware R48 and R82 had an altercation, the facility failed to ensure the administrator and state agency were notified immediately. Resident elopement incident was not reported immediately to the facility administrator and the state agency. R55 quarterly MDS dated 8/26/13, identified R55 had moderate cognitive impairment and was independent with most ADL's. Review of the facility's VA Investigation Packet, indicated on 10/08/13, LPN-C observed R55 on the camera entering the door to the facility unattended. LPN-C escorted R55 back into the memory care unit and notified the cart nurse about R55 being outside. Reviewing the Investigative Report completed by the facility the incident was submitted to state agency on 10/16/13 (eight days after the incident occurred.) During interview with licensed practical nurse (LPN)-C on 11/14/13, at 11:22 a.m., stated she had reported off to the cart nurse on R55's unit and thought the cart nurse would complete the state agency report and LPN-C did not notify the DON or administrator. LPN-C also verified that after a morning stand up meeting on 10/16/13, it was noticed no state agency report was made regarding the incident and a report was made that	F 226		

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F 226	Continued From page 14 day by her. Although the facility was aware of R55 elopement from the facility, the facility failed to ensure the administrator and state agency were notified immediately. During interview with the DON on 11/14/13, at 3:47 p.m., she reviewed and verified each incident and should have been reported immediately to her and the administrator and the state agency. During interview with the Administrator on 11/15/13, at 10:28 a.m., he then verified each incident and agreed he should have been notified and the state agency immediately.	F 226		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure individual resident preferences for bathing frequency were honored, for 1 of 1 resident (R35) reviewed for choices. Findings include: The quarterly Minimum Data Set (MDS) dated 9/11/13, revealed R35 was diagnosed with quadriplegia, his cognition was intact and he was	F 242	F242 Self-Determination-Right to Make Choices Facility failed to ensure individual resident preferences for bathing frequency were honored, for 1 of 1 resident(R35) reviewed for choices. Resident (R35) was interviewed for preferences of bathing. Resident was care planned for preferences. Residents are interviewed upon admission for preference of bathing frequency and preferences are put on temporary care plan and then on permanent care plan. Temporary care plan was revised to include number of times per week resident prefers bathing.	

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F 242	Continued From page 15 totally dependent on staff for bathing, transfers and personal hygiene. During interview on 11/15/13, at 9:55 a.m. R35 complained that he was not receiving baths at a sufficient frequency. R35 reported that he needed to bathe at least twice weekly. He stated, "Otherwise I get too hot and sweaty." He indicated he was scheduled to receive baths on Mondays and Thursdays. However, his Thursday bath was often canceled because the facility's bath aide was pulled to work on the floor. R35 verified his second weekly bath was not typically rescheduled and instead, he only received one bath for the week. R35 reported that for the past three months he had not consistently received two baths per week as per his need and preference. R35's care plan last revised 9/2013, indicated "assist with bathing 2x [times] weekly per bathing preference." When interviewed on 11/15/13, at 10:00 a.m., the nursing assistant (NA)-A stated she usually is assigned as a bath/shower aide and was familiar with R35 bathing preferences of requesting two a week. NA-A stated she has only been able to complete one bath a week for R35 in the last two months due to being "pulled to work on the floor as an aide." NA-A stated, " [it] has been bad the last month. " NA-A also verified that R35 has complained about not receiving his requested two baths a week but also has expressed understanding of her need to help due to lack of staff.	F 242	Staff were educated on the Resident Preferences Policy on 11-20-13 to ensure staff are providing for residents preferences. Staff not able to attend will be given a makeup packet or educated at mini-inservices held during regularly scheduled shifts. Staff will reschedule baths for another time of day or day of the week, if staff are unable to provide a bath at time scheduled to ensure that residents preferences are being met. Staff are completing audits doing Resident Interviews auditing for resident preferences weekly. Residents will be audited quarterly at care conferences and preferences will be care planned to ensure that preferences are being met. DON will summarize the findings of audits and present them to the QA Committee for further recommendations and changes. Completion date: January 1, 2014	1-1-14
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a	F 322	F322 Treatment/Services-Restore eating skills	

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F 322	Continued From page 16 resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure feeding tube placement was checked prior to medication administration for 2 of 2 residents (R16, R49) observed during a medication pass. Findings include: R49 did not have feeding tube placement checked prior to administration of medications. R49's physician's order sheets, dated 11/1/13, identified diagnoses of gastroparesis (a condition that reduces the ability of the stomach to empty its contents) and brain injury. R49 received medications through a feeding tube.	F 322	Facility failed to ensure feeding tube placement was checked prior to medication administration for 2 of 2 residents(R16, R49) observed during a medication pass. EMAR was updated to include staff to sign off that tube feeding placement was checked prior to administration of medications and feedings. Staff were educated on Tube Feeding Policy on 11-20-13 regarding the checking of tube feeding placement prior to administering medications or feedings. Staff not able to attend will be given a makeup packet or educated at mini-inservices held during regularly scheduled shifts. Policy was revised to include checking of placement prior to administration. DON or designee will audit administration of medications through tube feeding once daily for 2 weeks for each resident on tube feedings, then twice a week for each resident for 2 weeks, and then randomly to ensure continued compliance.	

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F 322	Continued From page 17 Observation on 11/13/13, at 11:36 a.m., revealed that licensed practical nurse (LPN)-B, crushed R49's Reglan tablet in a pill crusher. LPN-B proceeded to mix the crushed Reglan tablet in R49's methadone solution, stating we, "cocktail" the medications. LPN-B entered the room and flushed the feeding tube with approximately 30 milliliters (ml) of water with a syringe via pushing the fluid into the feeding tube. LPN-B poured the Reglan and methadone solution into the syringe and administered the medications through the feeding tube without checking placement. LPN-B then flushed the tube feeding with another 30 ml of water by pushing the water into the tube using the syringe. LPN-B removed her gloves and exited the room. R16 did not have feeding tube placement checked prior to administration of medications. R16's physician's order sheets, dated 11/1/1/3, revealed a diagnosis of chronic duodenal ileus (a disruption of the normal propulsive ability of the gastrointestinal tract). R16 received medications through a feeding tube. Observation on 11/14/13, at 8:26 a.m., revealed that LPN-A administered R16's medications through a feeding tube. LPN-A crushed all medications which included Ativan, Prevacid, vitamin D3, quetiapine and a daily vitamin after applying gloves and placed them into separate plastic medication cups. LPN-A dissolved each medication with 10 ml of water and stirred with a spoon to mix. LPN-A entered R49's room and proceeded to attach a syringe to R16's feeding tube, administer a 20 ml water flush by pushing the water into the tube with the syringe, then	F 322	DON will summarize the findings of the audits and present them to the QA Committee for further recommendations and changes. Completion Date: January 1, 2014	1-1-14

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F 322	Continued From page 18 administered the medications without checking for placement of the feeding tube. LPN-A administered each medication separately by pushing them into the tube via syringe. LPN-A was interviewed on 11/14/13, at 8:30 a.m., regarding facility practices for checking placement of feeding tubes prior to medication administration. She indicated she did not typically check placement of the feeding tube prior to administering medication. During an interview with the director of nursing (DON) on 11/14/13, at 9:53 a.m., the DON revealed her expectation would be for staff to check the placement of the feeding tube prior to any medication or enteral nutrition administration, unless there was a physician's order indicating otherwise. DON further indicated that placement should be checked using the auscultation method (a term for listening to the internal sounds of the body using a stethoscope). During an interview on 11/14/13, at 10:03 a.m., LPN-C confirmed the physician's orders for R16 and R49 did not include any specific indication not to check placement of their feeding tubes prior to medication administration or feedings. The facility's policy entitled Tube Feedings, dated 9/2013, lacked instructions for staff in relation to checking tube feeding placement prior to administration of medications.	F 322		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards	F 323	F 323: Facility did not ensure restraints were assessed for safety for resident R52.	

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F 323	Continued From page 19 as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility did not ensure restraints were assessed for safety for 1 of 1 resident (R52) reviewed for restraints. The facility also did not ensure environments were free of accident hazards related to falls for 1 of 4 residents (R82) reviewed for accidents. Findings include: R52 was observed to have a lap buddy in place. R52 had a physician order for a PRN (as needed) lap buddy dated 11/7/13, there was no assessment was found ensuring the lap buddy was the least restrictive or the restrictive device was safe for use with the resident. The quarterly Minimum Data Set (MDS) completed on 10/11/13, identified R52 was sometimes able to make herself understood and sometimes understood others. She had problems with short and long term memory and was considered to have severe impairment of her cognitive function. R52 needed extensive assistance with most of her activities of daily living including walking in and out of her room and all locomotion. Her balance was impaired and needed staff assistance to stabilize her during all transfers and transitions. R52 used her wheelchair primarily for locomotion.	F 323	The facility also did not ensure environments were free of accident hazards related to falls for resident R 82. R52 has had a safety risk assessment completed to assess the use of the lap buddy and ensure restraint safety on 11/11/13. R52's care plan and care sheets were updated on 11/7/13 to reflect the use of the lap buddy and when to use it. A behavior modification plan was also created on 11/7/13 to provide staff with guidelines as to when to appropriately use the lap buddy. R 82 had a post fall huddle completed investigating possible causes of falls. All residents with falls will have a post fall huddle completed to investigate possible causes of falls and interventions will be evaluated for appropriateness. All residents will have a safety risk assessment completed at least on admission, annually, quarterly, with any significant change and updated on an as needed basis when a new device is implemented or after any incident regarding side rails.	

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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 323	Continued From page 20 The care area assessment (CAA), completed on 10/21/13, noted R52 displayed short/ long term memory concerns and had a diagnosis that included dementia with behaviors, Alzheimer's disease and she resided on the memory care unit. She was able to answer yes/no to questions and at times could not understand cues or directions accurately. The CAA noted R52 had shown improvement in communication and physical strength/mobility in the past year and the resident ambulated with the use of a Merri-walker with staff supervision and stand by assist. An annual Safety Risk Data Collection was completed on 7/13/13, and reassessed on 10/8/13. The assessment identified R52 had internal risk factors for falls, specifically she needed assistance with bowel/bladder incontinence, displayed anxiety, Alzheimer's type dementia, paranoia and impaired judgment. The assessment identified physical devices used to attempt to keep R52 safe were half side rails, bed alarms and a hi-low bed. The use of these devises were needed, according to the assessment, due to decreased safety awareness, judgment and strength related to dementia. The devices were intended to enable R52's mobility, ensure proper positioning and to prevent falls. The specific safety interventions were personal alarms at all times, 1:1 from staff when restless and narcotic pain medications as needed. The reassessment also identified the use of diversional activities. There was no reassessment completed with the new order for a lap buddy that was obtained on 11/7/13 nor did the the reassessment on 10/8/13 mention the use of the Meri-walker.	F 323	DON or designee will audit 15 residents charts weekly to ensure residents are assessed for safety for 5 weeks, then 3 residents charts weekly for 5 more weeks to ensure continued compliance. DON or designee will record falls on a log and audit completion of post fall huddle investigations on this log as well to ensure continued compliance. Interventions will be evaluated with post fall huddle after fall occurs and in IDT for appropriateness. Staff were educated on safety risk assessment policy, restraint use and on need for routine assessments to be completed, and with new applications on 12/18/2013. Staff were educated on the post fall huddle and need for reevaluation of interventions with all falls. Staff not able to attend will be given a makeup packet or educated at mini in-service held during regular shift hours. The DON will summarize the findings of the audits and present them to the unit managers and to the QA committee for further recommendations and changes. Completion date: 1/1/14.	1-1-14

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F 323	Continued From page 21 R52's plan of care, initiated on 11/14/11, noted R52 was at risk for falls due to use of psychotherapeutic medication, decreased strength with ambulation, being unsure of surroundings, self-limitations and physical mobility. The goal of this problem area was R52 would not sustain any injury due to falls. Staff were directed to encourage R52 to participate in activities, document the resident's balance, range of motion and orthostatic blood pressure at least quarterly or as needed. A high/low bed was to be used for R52 and the bed was to be kept in the lowest position when she was in it. Personal alarms, including a motion sensor alarm when the resident was in bed, were to be used at all times and staff were to give R52 verbal reminders not to ambulate or transfer without assistance. R52 was to wear properly-fitting non-skid soled shoes for ambulation and transfers. Staff were to place items R52 frequently used within her reach. Staff were to use the lap buddy as needed for restlessness, attempts to self-transfer and to keep the resident safe according to the plan of care. The document did not specify when the plan was revised to include the use of the lap buddy. The nursing assistant care sheet, last updated on 11/11/13, did not indicate that a lap buddy could be used or when it was to be used. Upon review of the medical progress notes, it was noted the resident had fallen several times including but not limited to: 7/13/13, 10/6/13,11/4/13,11/8/13, 11/11/13 (twice), 11/12/13, 11/13/13, and 11/14/13. The only injury R52 sustained was a laceration to her left eye brow when she fell on 11/12/13. First aid was provided as a result.	F 323		

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F 323	Continued From page 22 On 11/14/13, at 1:55 p.m., R52 was sitting in her wheelchair with the lap buddy on and also a transfer belt in place, at the nurses station directly beside nursing assistant (NA)-G. Licensed practical nurse (LPN)-G was also at the nurses station documenting in the electronic medical record. On 11/14/13, at 2:05 p.m., NA-E and NA-F reported the lap buddy was being used as they needed to chart on several residents and the resident was so restless, she kept trying to stand up in her wheelchair and they were fearful, she would fall. They reported they were using the lap buddy to keep her safe. An interview with LPN-G was completed on 11/14/13, at 2:15 p.m. LPN-G reported they are no longer using the Meri walker for R52 as it had become unsafe to do so as the resident would attempt to crawl out of the devise. LPN-G also reported the lap buddy was being used to protect the resident and to prevent her from falling. She indicated the resident will frequently attempt to self-transfer or stand up, which will increase her risk of falls, as the resident does not remember that her balance is impaired and she cannot walk by herself safely. LPN-G was unable to locate an assessment for the lap buddy to ensure the devise was safe for the resident. She reported the resident cannot remove the lap buddy by herself and they use the device when no other intervention is effective. An interview with the director of nurses (DON) on 11/14/13, at 2:34 p.m. was completed. She indicated the lap buddy was a new device for R52 as of 11/7/13. The DON also reported she was unable to find evidence that an assessment of the	F 323		

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F 323	Continued From page 23 lap buddy, which was a restrictive device, had been completed for R52. She indicated a safety assessment was to be completed annually or with a significant change of condition but had not been done when the lap buddy had been added. The facility policy Safety Risk Data Collection & Evaluation, last reviewed on 10/2013, directed staff to complete a safety risk evaluation upon admission, quarterly or as condition or needs change throughout the resident's stay. If the evaluation finds the resident at risk, staff were directed to implement appropriate interventions/precautions and carry all risk factors forward to the resident care plan. According to the policy, physical devices which are used in an attempt to remove normal risks of living, violate the rights of resident; greatly reduce their quality of life and present significant physical and psychological risk could only be used to improve the resident's mobility and independent function, treat resident's medical symptoms; restrict movement to protect the resident, and as a last resort and after lessor restrictive measures have been taken and proven unsuccessful. In addition, restrictive devices could be used to prevent the resident from injuring self or others, with a physician's order, with consent of the resident or responsible party and when the benefits of the device outweigh the identified risks. R82 had fallen several times. No evidence of an investigation of causative factors or revision of interventions to possibly minimize the risk for further falls was found. In addition, R82 was found by staff lying on his right side between the bed mattress and side rail. No assessment was found regarding the removal of the bed rails and potential risk/safety.	F 323		

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F 323	Continued From page 24 R82 was admitted to the facility on 6/6/13, and resided on the secure memory care unit. A quarterly Minimum Data Set (MDS) was completed on 9/9/13, and noted R82 had moderate cognitive impairment with long and short memory problems. The MDS also identified R82 had diagnosis that included dementia with Lewy bodies (dementia associated with Parkinson 's disease), malaise/fatigue, insomnia, chronic pain, and stomach function disorder. His speech was unclear but he was usually able to make himself understood and understood others. R82 needed limited assistance of one staff for bed mobility, transfers, walking in/out of his room, locomotion on/off the unit, dressing, toileting and personal hygiene. He did have impaired balance during transitions from one surface to another. He used no device to ambulate. The MDS identified R82 had three falls since his previous assessment. The plan of care, established on 6/18/13, noted R82 was at risk for injury related to falls related to impaired balance/strength secondary to Lewy Body dementia and the established goal was for the resident to not be injured as result of a fall. The resident was considered a "Medium Fall Risk" and staff were instructed to provide the resident with a high/low bed and to keep the bed in the lowest position when the resident was in it. The staff were to provide personal alarms at all times and the resident was to wear a transfer belt at all times when out of bed and removed when in bed. Staff were to observe the resident's range of motion, balance and orthostatic blood pressure at least quarterly and document the results and report any abnormalities to the physician. The	F 323		

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F 323	Continued From page 25 staff were to keep the resident's glasses clean and encourage the resident to wear them. They were also to give R82 verbal reminders not to ambulate or transfer without assistance when appeared fatigued. They were to ensure the resident's environment was free of clutter and safety hazards and place things frequently used by resident within easy reach and ensure his environment had adequate lighting. The nursing assistant care sheet, last updated on 10/23/13, directed nursing assistants to keep the transfer belt on the resident at all times. Two nursing assistant were to assist the resident to walker if he seemed fatigued and also noted when the resident appeared fatigued; he liked to use a wheelchair. The care sheet did note the resident was a "medium fall risk " but no specific interventions were identified on this form. A Safety Risk Data Collection assessment was competed on 6/10/13, and reviewed on 9/7/13. The assessment indicated the resident did not have a history of falls. It noted the internal risk factors for falls were his hypertension, balance problems, and senile dementia. Physical devices being used were bilateral full side rails and these were being used for falls prevention and safety. R82 was able to demonstrate ability to appropriately utilize the device. A summary of the assessment noted the resident was a medium fall risk and had three falls since his admission related to imbalanced shuffled gait and impaired safety awareness and judgment secondary to senile delusion, Lewy Body dementia and malaise/fatigue. He was having tremors to his hands and ambulated and transferred independently. He was working with PT/OT (physician therapy/occupational therapy) for	F 323		

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F 323	Continued From page 26 strengthening however he was resistive. A quarterly review of the assessment was completed on 9/7/13 and no changes were noted. No changes in the plan of care were made. R82 fell on 9/6/13, at 3:51 a.m. He was found on the floor near the door to the unit and reported he had hit his head when he fell. He sustained a 1 centimeter(cm) red bruise to the left outer eyebrow area. Immediate actions taken were to continue tabs alarms and 15 minute checks were implemented. The only action taken per the incident report was the staff continued to observe the resident. The resident condition at the time of the incident was that he had a fall history and had tremors. He ambulated with staff assistance and was alert and oriented x2. There was no evidence that a comprehensive investigation was completed after the resident fell or alternative interventions were considered/implemented as result of the fall. R82 fell on 9/7/13, at 9:16 p.m. He was found of the bathroom door on his side on the floor with his feet out to the side. He did not have his shirt on. His shirt was lying on his bed with the tabs alarms attached to the shirt. No injuries were found. The immediate action taken was the implementation of 15 minute checks and observation of the resident. The resident's condition at the time of the incident was his side rails were up and his bed was at the lowest height. He was transferred from his bed or chair with staff assistance. He was considered to be alert and oriented x2. Medical risk factors possibly related to the incident were his fall history, incontinence and tremors. There was no evidence that a comprehensive investigation was completed after the resident fell or alternative	F 323		

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F 323	Continued From page 27 interventions were considered/implemented as result of the fall. R82 fell on 9/10/13, at 11:00 a.m. when while ambulating in the TV room on the units, he squatted over the dining room chair and then pulled it along with his right foot, which became stuck behind his left and he tripped, falling forward. The immediate action taken were neuro checks initiated, 15 minute checks continued and the resident was assisted out of the dining chair to the couch. Resident condition at the time of the incident was his fall history, confusion/disorientation, incontinence and tremors. There was no evidence that a comprehensive investigation was completed after the resident fell or alternative interventions were considered/implemented as result of the fall. On 9/17/13, at 8:30 a.m., R82 was found on the floor by the main TV area, lying on his left side. A three cm in diameter abrasion was found on his forehead and a five cm abrasion was found on his left hip. The immediate action taken were to cleansed the affected areas and apply Bacitracin (an antibiotic ointment) to the areas. The medical risk factors possibly related to the incident were the resident's fall history, confusion/disorientation, incontinency and tremors. There was no evidence that a comprehensive investigation was completed after the resident fell or alternative interventions were considered/implemented as result of the fall. On 9/21/13, at 2:25 a.m. R82 was found on the floor in the TV lounge. R82 informed staff that he had fallen and had hit his head while falling. A neuro assessment was completed. No obvious injury, swelling or deformities were observed.	F 323		

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F 323	Continued From page 28 The immediately action taken was ensuring the tabs alarms that were on the resident were functioning and staff 1:1 with resident to observe his behaviors and additional attempts to stand. The medical risk factors possibly related to the incident were the resident's fall history, confusion/disorientation, incontinency and tremors. There was no evidence that a comprehensive investigation was completed after the resident fell or alternative interventions were considered/implemented as result of the fall. On 9/25/13, at 1:01 a.m. staff responded to tabs alarm in R82's room and found R82 kneeling on the floor. An abrasion to his left knee, measuring 1 inch x 0.5 inch was noted. No other injuries were noted. Immediate Action taken were R82 was given first aid, toileted, ambulated, provided drink, vitals taken and neuros done. He was also moved from his room into the TV lounge for closer observations. The medical risk factors possibly related to the incident were the resident's fall history, confusion/disorientation, and incontinence. There was no evidence that a comprehensive investigation was completed after the resident fell or alternative interventions were considered/implemented as result of the fall. On 9/28/13, at 2:06 a.m. staff heard a loud "thud" from the TV lounge area and found resident lying on his right side on the floor next to the sofa. The immediate action taken was for the staff to assist the resident to the sitting position onto the sofa and observe for injury. R82 reported he had hit his head and so vital signs and neuros were taken. In addition, "physiologic needs were tended to and resident made comfortable." No immediate action taken other than vital signs and neuros. The medical risk factors possibly related	F 323		

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F 323	Continued From page 29 to the incident were the resident's fall history, incontinence and tremors. There was no evidence that a comprehensive investigation was completed after the resident fell or alternative interventions were considered/implemented as result of the fall. On 10/14/13, at 1:49 a.m. staff heard tabs alarm sound and observed R82 standing at the edge of the table. While approaching the resident, he fell backward hitting his head. Immediate actions taken were an assessment of R82 for injury and transfer to a wheelchair by two staff. Neuro checks and vital signs were done. R82 was then returned to the sofa per his personal preference. The medical risk factors possibly related to the incident were the resident's fall history, incontinence and tremors. There was no evidence that a comprehensive investigation was completed after the resident fell or alternative interventions were considered/implemented as result of the fall. On 10/28/13, at 12:06 a.m., an alarm in TV lounge sounded and R82 was observed lying on the floor in front of his wheelchair. No apparent injury was noted. The immediate actions taken were the continuation of tabs alarms, initiated fifteen minute checks, vital and neuro checks and staff were to remain in sight of the resident. The medical risk factors possibly related to the incident were the resident's fall history, incontinence, sensory limitations and tremors. There was no evidence that a comprehensive investigation was completed after the resident fell or alternative interventions were considered/implemented as result of the fall. An interview on 11/13/13, at 1:15 p.m. with the	F 323		

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F 323	Continued From page 30 director of nurses (DON) was competed. She reported after a fall occurs, staff are expected to complete the incident report and implement immediate interventions to prevent an immediate reoccurrence of the incident. The next working day at the multidisciplinary team meeting, the fall would be discussed, causative factors reviewed and further implementations initiated. She reports that all this was a part of the Quality Assurance (QA) process and was not kept in the medical record. A request was made for evidence of comprehensive post fall assessment/investigations and implementation of interventions to minimize further falls with injury to R82 were requested. None received. On 11/5/13, at 1:15 a.m. R82 was found lying on his right side between the bed mattress and side rail. Staff assisted the resident back into a supine position onto the bed. R82 denied any injury. The resident was assessed for injury and bruising was noted on the right buttock and hip. In addition, an abrasion to the right hip was noted. The immediate actions taken were to remove from the "dangerous situation" and returned to his bed in the supine position, assessed for injury, neuros and vitals competed, and first aid given to the abrasion to the right hip. The medical risk factors possibly related to the incident were the resident's fall history, incontinence, sensory limitations and tremors. There was no evidence that a comprehensive investigation was completed after the incident or alternative interventions were considered/implemented. An interview with LPN-H was competed on 11/14/13, at 3:03 p.m. and discussed the incident where the resident was found between the side rail and his mattress. LPN-H was unable to	F 323		

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F 323	Continued From page 31 locate any further information regarding post incident assessment or further assessment of the side rails/mattress. She reported she was unsure of the side rails were being used at the present time. She did indicate the resident did have a different bed at the present time than he did when the incident occurred. An interview with the DON on 11/14/13, at 5:05 p.m. was completed. The incident of R82 being found between the side rail and mattress was reviewed with the DON and she reported she was called immediately after the incident and she told the staff to immediately remove the side rails from the bed. She further reported the next interdisciplinary team meeting, the incident was discussed and the unit care manager was given the assignment to ensure the safety of the resident by completing further assessments to determine the safety of the resident without the side rails. The DON reported she had assumed this staff had done this but had not. She indicated the care manager no longer worked at the facility. The policy Resident Accident/Incident Investigation and Completion of Report, last revised on 9/18/13, directed the nurse in charge to investigate all incidents as soon as possible after the incident and complete the Incident Report form. The unit manager was to review the incident report and the interdisciplinary team would review the report following the incident.	F 323		
	The policy Falls Risk Assessment, reviewed 9/19/13, directed nursing staff to complete the Fall Risk Assessment upon admission, 30 days from admission, 60 days from admission and 90 plus days from admission. The Fall Risk			

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F 323	Continued From page 32 Assessment would be based on resident history, medications, cognitive status, general health and other fall risk factors. The resident's risk would be measured on a rating scale of Low risk, Medium risk and High risk. Nursing staff were to determine and implement interventions on the initial care plan and change the plan of care to reflect the specific needs of the resident.	F 323		
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF-PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure staffing was	F 353	F353 Sufficient 24-hour Nursing Staff Per Care Plans Facility failed to ensure staffing was provided to meet and maintain the residents physical, mental, and psychosocial well-being for 4 of 35 residents(R52, R82, R35, R40). Staff were educated on 11-20-13 on fall prevention interventions, and resources to use in circumstances regarding falls. Staff were educated on 11-20-13 about proper useage of restraints. Staff not able to attend will be given a makeup packet or educated at mini in-service held during regular shift hours. Falls will be assessed and compared in relation to staffing levels to determine correlation and will be recorded on the Post Fall Huddle form.	

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	245438	A. BUILDING _____ B. WING _____	11/15/2013

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 353	Continued From page 33 provided to meet and maintain the residents physical, mental and psychosocial well-being for 4 of 35 residents (R52, R82, R35, R40). Findings include: Staff used inappropriate fall prevention methods due to insufficient staffing. The quarterly Minimum Data Set (MDS) completed on 10/11/13, reported R52 was sometimes able to make herself understood and sometimes understood others. She had problems with short and long term memory and was considered to have severe impairment of her cognitive function. R52 needed extensive assistance with most of her activities of daily living including walking in and out of her room and all locomotion. Her balance was impaired and needed staff assistance to stabilize her during all transfers and transitions. R52 used her wheelchair primarily for locomotion. The care area assessment (CAA), completed on 10/21/13, noted R52 displayed short and long term memory and had a diagnosis of Dementia with behavior, Alzheimer's and resided on the memory care unit. During the CAA assessment, R52 was assisted by one staff with activities of daily living but had impaired safety and judgment awareness. A review of the nurse's progress notes indicated since 10/1/13 to 11/13/13, R52 had fell seven times. On 11/12/13, at 10:24 p.m. R52 fell and sustained a 1 centimeter (cm) laceration to the right eyebrow. On 11/11/13, at 6:30 p.m., R52 fell from her wheelchair and sustained no injury. On 11/11/13, at 3:05 a.m. she was found lying on the	F 353	Facility is utilizing pool staffing agencies to fill positions until staffing levels are where need to be as recommended by facility. If staffing does not accomodate residents preferences in bathing, staff will make every effort to reschedule bath to another shift or day. Staff are completing Resident Interviews weekly to ensure residents needs and preferences are being met regarding bathing and call light responses. DON or designee will conduct five call light audits a week for 4 weeks and then as needed to ensure continued compliance in meeting residents needs. DON will summarize the findings of the audits and present them to the nurse managers and QA committee for further recommendations and changes. Completion Date: January 1, 2014	1-1-14

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F 353	Continued From page 34 floor of her bedroom. She was not injured. On 11/8/13, at 4:50 p.m. she fell when attempting to stand from her wheelchair and tipped over the wheelchair with her in it. She sustained no injury. On 11/4/13, at 5:53 p.m., while staff were attending to other residents, R52 fell in the dining room. She was found on the floor, still in the dining room chair. No injuries were found. On 10/31/13, at 10:04 a.m. she was found on the floor of her bedroom. No injuries were noted. On 10/6/13, at 2:13 p.m. she was found on the floor of her bedroom with no apparent injury. The nurse's progress notes indicated numerous episodes of restless behavior, attempting to stand or transfer herself without staff assistance or behaviors that set off her personal alarms. A lap buddy was ordered PRN (as needed) on 11/7/13. An interview was completed with nursing assistant (NA)-H on 11/13/13, at 7:45 p.m. He reported an incident with R52 directly related to sufficient staffing. He reported he could not specifically report when the incident happened but felt it was less than one month previous. He reported that he and a former nursing assistant worked an evening on the memory care unit short (only two nursing assistants had been scheduled). He indicated that this was an impossible task due to the behaviors on the unit but especially R52. He indicated she was very restless and frequently attempting to stand out of her chair. He reported he knew she was a significant fall risk and was fearful she would fall and harm herself. He indicated that even though he was not to do it, he had used a lap buddy (which was not ordered at that time) on R52 to prevent her from falling but on this evening was unable to find a lap buddy. He indicated he and	F 353		

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

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F 353	Continued From page 35 his coworker tried everything they could think of to help the resident and were spending so much time with R52 that other residents were being neglected. He reported his co-worker told him to put the resident in a chair and wrap a transfer belt around the resident and the chair to prevent her from standing. He indicated he did not know what else to do and so as a result, he and his co-worker did use a transfer belt and wrapped it around the resident and the chair, so that they could provide cares to the other residents on the unit. He indicated the director of nurses found out about this incident and as a result he was given a final warning, which meant any further incident would lead to his dismissal from the facility. He indicated his co-worker was fired from the facility related to this incident. An interview with human resources coordinator (HRC) was completed on 11/13/13, at 4:25 p.m. She reported the staff were dealing with very demanding residents and discussed R52, who she reported needed a 1:1 staff member to keep her safe as she tried to stand and walk without assistance frequently. On 11/13/13, at 5:45 p.m., R52 was observed to be sitting in a wheelchair in the dining area with a lap buddy in place. On 11/14/13, at 2:00 p.m., R52 was observed to be sitting at the nursing station on the Memory Care unit directly by a nursing assistant (NA)-G, who reported she was observing the resident. A lap buddy was in place. On 11/14/13, at 2:05 p.m., NA-F and NA-E reported the lap buddy was being used on R52 as they needed to chart on several other residents	F 353		

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F 353	Continued From page 36 and the resident was so restless, she kept trying to stand up in her wheelchair almost continuously. They reported they were using the lap buddy so they could get their work done and keep her safe. An interview with licensed practical nurse (LPN) -G was completed on 11/14/13, at 2:15 p.m. She reported R52 the resident will frequently attempt to self-transfer or stand up, which will increase her risk of falls, as the resident does not remember that her balance is impaired and she cannot walk by herself safely. She reported she believed some of R52's falls were related to insufficient staffing. LPN-G reported had frequently asked for help to manage R52's behavior and keep her safe but help was not forthcoming. She reported there were several residents, who were at high risk for falls and there were not enough staff to manage. She indicated she felt that short staffing was a major issue at the facility. R82 was reported to have falls directly related to insufficient staffing. A quarterly MDS was completed on 9/9/13, and noted R82 had moderate cognitive impairment with long and short memory problems and diagnosis that included dementia with Lewy bodies (dementia associated with Parkinson's disease) . His speech was unclear but he was usually able to make himself understood and understood others. R82 needed limited assistance of one staff for bed mobility, transfers, walking in/out of his room, locomotion on/off the unit, dressing, toileting and personal hygiene. He did have impaired balance during transitions from one surface to another. He used no device to ambulate. The quarterly MDS noted the resident	F 353		

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F 353	Continued From page 37 had two falls without injury and one fall with minor injury in the previous quarter. R82 fell on 9/6/13, at 3:51 a.m. He was found on the floor near the door to the unit and reported he had hit his head when he fell. He sustained a 1 centimeter (cm) red bruise to the left outer eyebrow area. R82 fell on 9/7/13, at 9:16 p.m. He was found of the bathroom door on his side on the floor with his feet out to the side. He did not have his shirt on. His shirt was lying on his bed with the tabs alarms attached to the shirt. No injuries were found. R82 fell on 9/10/13, at 11:00 a.m. when while ambulating in the TV room on the units, he squatted over the dining room chair and then pulled it along with his right foot, which became stuck behind his left and he tripped, falling forward. On 9/17/13, at 8:30 a.m., R82 was found on the floor by the main TV area, lying on his left side. A three cm in diameter abrasion was found on his forehead and a five cm abrasion was found on his left hip. On 9/21/13, at 2:25 a.m. R82 was found on the floor in the TV lounge. R82 informed staff that he had fallen and had hit his head while falling. A neuro assessment was completed. No obvious injury, swelling or deformities were observed. resident fell or alternative interventions were considered/implemented as result of the fall. On 9/25/13, at 1:01 a.m. staff responded to tabs alarm in R82's room and found R82 kneeling on	F 353		

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F 353	Continued From page 38 the floor. An abrasion to his left knee, measuring 1 inch x 0.5 inch was noted. No other injuries were noted. On 9/28/13, at 2:06 a.m. staff heard a loud thud from the TV lounge area and found resident lying on his right side on the floor next to the sofa. R82 reported he had hit his head On 10/14/13, at 1:49 a.m. staff heard tabs alarm sound and observed R82 standing at the edge of the table. While approaching the resident, he fell backward hitting his head. On 10/28/13, at 12:06 a.m., an alarm in TV lounge sounded and R82 was observed lying on the floor in front of his wheelchair. No apparent injury was noted. An interview with licensed practical nurse (LPN) -G was completed on 11/14/13, at 2:15 p.m. She reported R82 had an increase in falls related to staffing shortage. She reported that staff are not able to respond as quickly as they should to R82 as they are caring for other residents and so the resident falls. R35's bathing needs/preferences were not honored due to insufficient staffing within the facility. He also reported long response times to call light requests. The quarterly MDS dated 9/11/13, revealed R35 was diagnosed with quadriplegia, his cognition was intact and he was totally dependent on staff for bed mobility, eating, dressing, bathing, transfers and personal hygiene. During interview on 11/15/13, at 9:55 a.m. R35	F 353		

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F 353	Continued From page 39 complained that insufficient staffing within the facility had resulted in him not receiving baths at a sufficient frequency. R35 reported that he needed to bathe at least twice weekly. He stated, "Otherwise I get too hot and sweaty." He indicated he was scheduled to receive baths on Mondays and Thursdays. However, his Thursday bath was often canceled because the facility's bath aide was pulled to work on the floor. R35 verified his second weekly bath was not typically rescheduled and instead, he only received one bath for the week. R35 reported that for the past three months he had not consistently received two baths per week as per his need and preference. R35 also expressed concerns of untimely call light response times. He reported waits of 30 to 45 minutes at times for staff to respond to his call light requests. R35 indicated that he typically used his call light for comfort requests, such as assistance for adjusting his pillow or repositioning. R35 added, call light response time was worse during morning cares and breakfast hours. During interview on 11/15/13, at 10:00 a.m., the nursing assistant (NA)-A stated she usually is assigned as a bath/shower aide and was familiar with R35 bathing preferences of requesting two a week. NA-A stated she has only been able to complete one bath a week for R35 in the last two months due to being "pulled to work on the floor as an aide." NA-A stated, " [it] has been bad the last month. " NA-A also verified that R35 has complained about not receiving his requested two baths a week but also has expressed understanding of her need to help due to lack of staff. R40 reported concerns regarding staffing	F 353		

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F 353	Continued From page 40 An interview with R40 on 11/14/13 at 9:08 a.m. revealed he had used the call light on 11/14/13, at 5:30 a.m. for assistance. He went on to report that staff came to his room and told him, he would have to wait for assistance. R40 put the call light on for the second time, at 6:00 a.m. as staff had not responded to his earlier request. R40 stated at 6:45 a.m. staff finally came into assist with cares for the day. A Minimum Data Set (MDS) dated 8/19/13 indicated R40 required the assistance of a whole body mechanical lift for transfers and 2 staff. An interview on 11/14/13, at 9:18 a.m. with nursing assistant (NA)-C revealed R40 liked to get up early and had to wait for assistance. NA-C stated that staff are not able to get to residents timely for assistance due to being short staffed. NA-C stated that typically baths for residents will be cut due to not having enough staff. Employee interviews verified concerns of insufficient staffing within the facility. During interview on 11/14/13, at 3:48 p.m. registered nurse (RN)-B reported the facility did not have sufficient staffing available to meet resident needs in a timely manner. She stated that the bath aides were frequently pulled to work on the floor, which resulted in missed baths for some of the residents. She stated, "The acuity of the patients is very high." RN-B explained there were 11 residents on the West wing who required two staff for transfers, with one resident who required assistance from only one staff. She added there were eight residents with "heavy care" needs on the North wing, including one resident who required a wound vac. RN-B stated, "We just had an admission today. Why are we	F 353		

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F 353	Continued From page 41 taking a new admission when we can't handle what we have?" RN-B stressed, "The poor aides, they can't get their work done. It's the acuity of the residents." RN-B confirmed feeling some of her staff were getting burnt out. RN-B added that some of the adjustments being made with the licensed nursing roles within the facility were also adding to the difficulty of meeting resident needs in a timely manner. She explained that with the facility's new ownership, the East wing (memory care) nurse manager position was changed to an MDS coordinator, which left the North and West nurse managers, each responsible to cover half of the East wing, which was located on the opposite side of the facility. She added, the facility also removed the position of a wound nurse and those duties were transferred to the North and West nurse managers as well. RN-B indicated she felt she was assigned new responsibilities, without having received the proper training and without someone available to support her and answer questions as she transitioned to her new role within the facility. RN-B expressed frustration over the facility's recently added assistant director of nursing and MDS positions, when she felt more nursing support was needed to meet resident needs on the floor. During interview on 11/14/13, at 4:07 p.m. licensed practical nurse (LPN)-F reported concerns of insufficient staffing within the facility and stated, "There are times when there are two aides and one nurse on the East wing and that is not enough." LPN-F indicated that the facility was not able to fill shifts when staff called in sick. During interview on 11/14/13, at 2:25 p.m., LPN-D indicated staffing was short a lot and there were	F 353		

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F 353	Continued From page 42 not enough nursing assistants. LPN-D described that when they are short nursing assistants, the bath assistant gets pulled to work the floor, and then the baths aren't done. LPN-D further indicated that staffing was worse on the locked unit because there are residents who need almost constant one to one attention and when it was the nurse's turn to sit with a resident, they would get way behind passing medications. LPN-D indicated being in nursing for many years, and the current experience with poor staffing was the worst ever seen. LPN-G was interviewed on 11/14/13, at 2:15 p.m. and reported concerns regarding the facility being short of staff and reported felt 2 residents (R52, R82) had falls directly from the staffing being so short. An interview with human resources coordinator (HRC) was completed on 11/13/13, at 4:25 p.m. She reported that staffing levels are done according to corporate office directives and the acuity of residents at the facility are not taken into consideration. She reported since the new corporation purchased the facility, there have been staff cuts and several staff have quit. She indicated although none of the staff told her that they were leaving due to staff shortage but felt this was the biggest reason for them leaving. She reported nursing assistants who were assigned to bathe residents had their hours have been cut. She reports that these nursing assistants at times are sent home early in their shift or are pulled to work "the floor." She reported the facility used to take pride in the fact that they gave residents two bathes per week and now are only able to schedule staff to give bathes once per week. She reported she was aware the nursing schedules were posted with "holes" ,	F 353		

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F 353	Continued From page 43 meaning that minimum staffing schedules were not met and indicated the director of nurses (DON) was informed when this happened. She also reported if staff call and say there are not able to cover their shift, efforts will be made to try to replace them but are not always able to do so at times and as result the nursing assistants will "work short." An interview on 11/13/13, at 2:10 p.m. with the DON was completed. She reported that staffing guidelines are developed by the owners of the facility and no acuity study is done to determine the staff needed to provide care for the residents. She denied that any positions were cut at the present time. She reported previously hours for staff to bathe residents had been cut but there are now staffed at the same level they were prior to the new owners. She indicated there may be some positions cut in the future but not at the present time.	F 353		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census.	F 356	F356 Posted Nurse Staffing Information Facility failed to ensure the required daily nurse staffing information was updated and included the actual hours for the day shift, evening shift, and night shift. Nursing Staffing Information Sheet was updated on 11-14-13 to include actual hours. Staff were educated on 12-19-13 on Staffing Policy.	

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F 356	Continued From page 44 The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the required daily nurse staffing information was updated daily and included the actual hours for the day shift, evening shift and night shift. This had the potential to affect all 71 residents currently residing in the facility, as well as family members or the general public who may wish to review this information. Findings include: During the initial tour on 11/12/13, at 6:45 a.m., the nurse staff posting was observed on the wall next to the main nurse's station. The posting was dated Sunday November 10th 2013 and did not include the actual hours listed for each working shift. When interviewed on 11/14/13, at 1:20 p.m., the staffing coordinator (SC)-A stated she usually does not work weekends and the charge nurse is responsible to keep the nurse posting updated.	F 356	Staff not able to attend will be given a makeup packet or educated at mini in-service held during regular shift hours. Staffing Policy was developed, to include staffing guidelines and posting of Nurse Staffing Information Sheet. DON or designee will audit Nursing Staffing Information Sheet five times a week to ensure that it is posted and up to date. DON will summarize the findings of audits and present them to the QA Committee for further recommendations and changes. Completion Date: January 1, 2014	1-1-14

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 _____	11/15/2013

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 356	Continued From page 45 SC-A did verify that on 11/12/13, Sunday 11/10/13, was posted. A facility policy regarding the nurse staff posting was requested on 11/14/13, one was not provided.	F 356		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on interview, observation, documentation review the facility failed to follow proper sanitation practices with the deep fat fryer, convection ovens, walls, and griddle in the kitchen to ensure that food served to residents was prepared under sanitary conditions, which had the potential to affect 66 of 71 residents who ate food prepared in the kitchen. In addition proper hand hygiene was not followed during meal service for 3 residents observed during dining (R94, R83 and R9). A tour of the kitchen was completed on 11/12/13, at 7:01 a.m. The deep fat fryer contained cooked food particles floating in the oil. The kitchen manager indicated that the deep fat fryer should be strained after use. The stove top contained food particles. The convection oven both were soiled and brown stains were observed	F 371	F371-Food Prepared under Sanitary Conditions. All equipment was immediately cleaned. New cleaning lists created and implemented on 12/2/13. Audits will be done to ensure proper cleaning 3 x weekly for 4 weeks then weekly to ensure continued compliance. Griddle top now has sheet pans on top to prevent contamination from crumbs when preparing food. Items not properly labeled with date were discarded immediately. Dietary Meeting held on 11/14/13 included review of date marking and labeling of all items, and proper cleaning of items. Audits will be done 3x weekly for 4 weeks then weekly of date marking and labeling to ensure continued compliance. Nursing meeting was held on 12/19/13 and staff were educated on the Policy on feeding residents and no bare hand contact with foods.	

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F 371	Continued From page 46 in the ovens. The kitchen manager indicated the ovens were to be cleaned monthly. The wall by the garbage and deep fat fryer were soiled with food debris. The kitchen manager indicated that the wall should be wiped off after cooking on the stove, using the deep fat fryer or when the garbage is taken out. The meat slicer had dried onion on the blade of the meat slice. The kitchen manager indicated that the meat slicer had not been used in a while. The dishwashing area had a free standing white fan with black particles on the edges of the fan blade. The fan stand was soiled. The kitchen manager indicated that the fan should be cleaned once a month. The Rosewood refrigerator contained a gallon container ¾ full of chocolate milk with no date on it when the container was opened. The refrigerator also contained a whole milk gallon container 2/3 full with no date on it when the container was opened and a gallon of 1% milk ½ full with no date on it when the container was opened. A 16 ounce open container of whipped topping was in the freezer with no dated that it was opened on it. A pound of margarine in a container was observed on the counter with no date when it was opened and put on the counter. The dietary director indicated that items should be dated when they are opened. The refrigerator in the checker board room had food/beverage spills throughout the refrigerator. The dietary director confirmed that the refrigerator was not clean. On 11/13/13, at 4:30 p.m. the kitchen garbage was overflowing with garbage by the kitchen sink to wash hands. The dietary director indicated that the garbage should not be overflowing. The griddle on the stove had food particles on it. The dietary director indicated that staff should have cleaned the griddle between meals. The dietary	F 371	Staff not able to attend will be given a makeup packet or educated at mini in-services held during regular shift hours. Nursing will complete audits on 8 meals weekly for 4 weeks, then 4 meals for 2 weeks and as needed to ensure continued compliance and ensure food safety while assisting residents to eat. CDM and DON will summarize audit findings and present to QA Committee for further suggestions or changes. Completion Date: January 1, 2014	1-1-14

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F 371	Continued From page 47 director indicated the convection ovens were cleaned weekly. The cleaning schedule indicated the convection ovens were cleaned every day. The dietary manager stated that the convection ovens were not cleaned. The wall by the deep fat fryer was soiled with food particles. The cook-A stated that the wall was not wiped down after using the deep fat fryer. The dietary director confirmed that the wall was not clean. The facility policy Food Storage undated indicated any items that have been opened or partially used are dated and sealed before returning to the storage area. On 11/12/13, at 8:52 a.m. nursing assistant (NA) -D was observed feeding toast with jelly on it with a bare hand to R45. After R45 had taken a bite, NA-D placed the toast down on the table directly with no barrier between the toast and table. NA-D picked up the toast and gave R45 another bit, as NA-D was putting the toast with jelly down it fell out of NA-D's bare hand and fell on the jelly side on the table. NA-D picked up the toast and jelly with a bare hand and placed on a napkin. NA-D gave R45 a drink and picked up the toast with jelly and gave R45 another bite. An interview on 11/14/13, at 9:44 a.m. with NA-D indicated that NA-D should not have placed the toast on the table directly. On 11/13/13, at 6:47 p.m. NA-B was observed with bare hands assisting R94 to eat a few bites of the meal with a fork. NA-B then went to R83 and touched R83's shoulders with unwashed hands, then picked up the fork and assisted R83 with a few bites of the meal. NA-B went to R9 and with unwashed hands touched R9's shoulders with bare hands, picked up the fork and assisted R9 with a few bites of the meal. R9 was holding onto the fork to eat prior to NA-B assisting R9.	F 371		

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F 371	Continued From page 48 An interview on 11/13/13, at 7:31 p.m. with NA-B revealed that NA-B was supposed to wash hands in between residents when assisting with feeding. The facility policy reviewed on 10/18/13, indicated to wash or hand sanitize when assisting a resident with meals.	F 371		

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OMB NO. 0938-0391

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Talahi Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	Pick JB 12-23-13 RECEIVED DEC 23 2013 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC 11-18-13
EXIT: 11-15-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Raymond Dykhuizen
TITLE: ADMINISTRATOR
(X6) DATE: 12/20/2013

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

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K 000	Continued From page 1 By e-mail to: Barbara.lundberg@state.mn.us and Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Talahi Center is a 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.	K 000		

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K 000	Continued From page 2 The building is protected by a complete fire sprinkler system. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a licensed capacity of 77 beds and had a census of 69 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on review of reports, records and interview, it was determined that the facility failed to vary the times and conditions for the required fire drills within the last 12-month period. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect the safety of all 69 residents, visitors and staff. Findings include:	K 050	K050 Life Safety Code Standard Facility failed to vary the times and conditions for the required fire drills within the last 12 month period. Facility failed to conduct a fire drill for the day shift on the 2nd quarter and also a fire drill for the evening shift in the 3rd quarter of the calendar year. Facility Maintenance Supervisor established a schedule for future fire drills, alternating the times and conditions of required fire drills for the upcoming year. Maintenance Supervisor will oversee fire drills. follow schedule of fire drills and ensure completion monthly. Fire drills will be audited on last day of month by Administrator or designee to ensure completion of fire drills monthly.	

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K 050	Continued From page 3 On facility tour between 1:00 PM and 4:00 PM on 11/13/2013, during a documentation review of the available fire drill reports for the last 12 months and interview with the Maintenance Supervisor (KN), it was revealed that the facility failed to conduct a fire drill for the day shift in the 2nd quarter and also a fire drill for the evening shift in the 3rd quarter of the calendar year. This deficient practice was verified by the Maintenance Supervisor (KN).	K 050	The Maintenance Supervisor along with the Administrator will summarize the findings of audits and presenet them to the QA committee for further recommendations and changes. Completion Date: January 1, 2014	1-1-14