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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: PHOI

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) **241543700**

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

4. TYPE OF ACTION: **7** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) 2/23/2012

6. DATE OF SURVEY ~~02/24/2012~~ (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 IMR	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	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 :
William Eckberg, HFE NE II 02/28/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Susan N. Leppke, Program Specialist 03/01/2012 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 03/26/2012 ML.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
02/08/2012
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM

At the time of the standard survey completed on December 22, 2011, the facility was not in substantial compliance with the participation requirements and the most serious deficiencies were isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections are required. The facility was not given an opportunity to correct before remedies were imposed.

As a result of the survey, we imposed state monitoring, effective January 11, 2012. In addition, we recommended to the Centers for Medicare and Medicaid Services (CMS) Regional Office that the following remedy be imposed:

- A per instance civil money penalty (CMP) in the amount of $1,500.00 for the deficiency cited at F314, effective December 22, 2011, for a total amount of $1,500.00.

- Mandatory denial of payment for new Medicare and Medicaid admissions effective March 22, 2012. (42 CFR488.417 (b))

2/23/2012

On February 24, 2012, the Minnesota Department of Health completed a Post Certification Revisit and verified that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 22, 2011, effective February 13, 2012. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective February 13, 2012.

In addition, this Department recommended to the CMS Region V Office the following actions:

- A per instance civil money penalty of $1,500.00 for the deficiency cited at 314, effective December 22, 2011 , for a total penalty of $1,500.00 will remain in effect. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective March 22, 2012 be rescinded as of February 13, 2012. (42 CFR488.417 (b))

See attached CMS-2567B forms for the results of the February 24, 2012 revisit.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

March 1, 2012 CMS Certification Number (CCN):245438

Mr. Darwin Schwantes, Administrator
Talahi Care Center
1717 University Drive Southeast
Saint Cloud, Minnesota 56304

Dear Mr. Schwantes:

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 February 13, 2012 the above facility is recommended for:

77 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Susan N. Leppke

Susan N. Leppke, Program Specialist
Program Assurance Unit, Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4121 Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

February 28, 2012

Mr. Darwin Schwantes, Administrator
Talahi Care Center
1717 University Drive Southeast
Saint Cloud, Minnesota 56304

RE: Project Number S5438023

Dear Mr. Schwantes:

On January 6, 2012, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective January 11, 2012. (42 CFR 488.422)

On January 31, 2012, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Per instance civil money penalty of $1,500.00 for the deficiency cited at 314, effective December 22, 2011, for a total penalty of $1,500.00. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective March 22, 2012. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for a standard survey completed on December 22, 2011. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On February 24, 2012, the Minnesota Department of Health completed a Post Certification Revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 22, 2011. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 13, 2012. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 22, 2011, as of February 13, 2012.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective February 13, 2012.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of January 31, 2012:

• Per instance civil money penalty of $1,500.00 for the deficiency cited at 314, effective December 22, 2011 , for a total penalty of $1,500.00 will remain in effect. (42 CFR 488.430 through 488.444)

• Mandatory denial of payment for new Medicare and Medicaid admissions effective March 22, 2012 be rescinded as of February 13, 2012. (42 CFR488.417 (b))

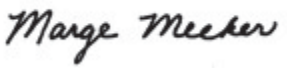
The CMS Region V Office will notify you of their determination regarding the imposed remedies and appeal rights.

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

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,



Marge Meeker, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (320) 223-7317 Fax: (320) 223-7348

Enclosure

cc: Licensing and Certification File 5438r12.rtf

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 02/23/2012	~~2/24/2012~~

Name of Facility	Street Address, City, State, Zip Code
TALAHI CARE 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 **F0241** Reg. # **483.15(a)** LSC	Correction Completed **02/13/2012**	ID Prefix **F0248** Reg. # **483.15(f)(1)** LSC	Correction Completed **02/01/2012**	ID Prefix **F0272** Reg. # **483.20(b)(1)** LSC	Correction Completed **02/13/2012**
ID Prefix **F0276** Reg. # **483.20(c)** LSC	Correction Completed **02/13/2012**	ID Prefix **F0278** Reg. # **483.20(g) - (j)** LSC	Correction Completed **02/13/2012**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **02/13/2012**
ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **02/13/2012**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **02/13/2012**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **02/13/2012**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **02/13/2012**	ID Prefix **F0325** Reg. # **483.25(i)** LSC	Correction Completed **02/13/2012**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **02/13/2012**
ID Prefix **F0425** Reg. # **483.60(a),(b)** LSC	Correction Completed **02/13/2012**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **02/13/2012**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **02/03/2012**

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	MM/SNL	02/28/2012	21978	02/24/2012
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 12/22/2011

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: PHOI

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) **241543700**

3. NAME AND ADDRESS OF FACILITY
(L3) **TALAHI CARE 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)

6. DATE OF SURVEY **12/22/2011** (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 IMR	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	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 :
William Eckberg, HFE NE II 01/26/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Susan N. Leppke, Program Specialist 02/01/2012 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
pOSTED 2/8/2012 ML.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM

At the time of the standard survey completed on December 22, 2011, the facility was not in substantial compliance with the participation requirements and the most serious deficiencies were isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections are required. The facility was not given an opportunity to correct before remedies were imposed.

As a result of the survey, we imposed state monitoring, effective January 11, 2012. In addition, we recommended to the Centers for Medicare and Medicaid Services (CMS) Regional Office that the following remedy be imposed:

- A per instance civil money penalty (CMP) in the amount of $1,500.00 for the deficiency cited at F314, effective December 22, 2011, for a total amount of $1,500.00.

See attached CMS-2567 for survey results. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1060 0002 3051 4327

January 6, 2012

Mr. Darwin Schwantes, Administrator
Talahi Care Center
1717 University Drive Southeast
Saint Cloud, Minnesota 56304

RE: Project Number S5438023

Dear Mr. Schwantes:

On December 22, 2011, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the attached CMS-2567, whereby significant corrections are required. A copy of the Statement of Deficiencies (CMS-2567 and/or Form A) is enclosed.

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

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

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

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

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

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

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

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:

Marge Meeker
Minnesota Department of Health
3333 West Division Street, Suite 212
St. Cloud, Minnesota 56301-4557

Telephone: (320) 223-7317

Fax: (320) 223-7348

NO 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 they have deficiencies of actual harm or above cited at the current survey, and on the previous standard or intervening survey (i.e. any survey between the current survey and the last standard survey). A level K deficiency (widespread deficiencies that constituted actual harm that was immediate jeopardy) whereby significant corrections were required was issued pursuant to a survey completed on December 13, 2010. The current survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G). Your facility meets the criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

- State Monitoring effective January 11, 2012. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Per instance civil money penalty of $1,500.00 for the deficiency cited at 314, effective December 22, 2011, for a total penalty of $1,500.00. (42 CFR 488.430 through 488.444)

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

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 remedy be imposed:

• 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. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved 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.

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

If substantial compliance with the regulations is not verified by March 22, 2012 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 22, 2012 (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.

Sincerely,

Marge Meeker

Marge Meeker, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (320) 223-7317 Fax: (320) 223-7348

Enclosure

cc: Licensing and Certification File

5438s12.rtf

JAN 23 2012

PRINTED: 01/05/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245438	A. BUILDING _____ B. WING _____	12/22/2011

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

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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.	F 000		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide a dignified dining environment for residents that required assistance for 10 of 10 residents (R14, R30, R66, R45, R8, R7, R62, R89, R18 and R40). Findings include: During continuous dining observation from 5:54 p.m. to 6:45 p.m. on 12/19/11 the area known as the nook of the dining room contained four long individual rectangular tables that were placed in the shape of a rectangle with the center of the table remaining open. Resident's who required less assistance were seated at individual tables	F 241	F241 Problem: Facility failed to provide a dignified dining experience/environment for residents that require assistance. New tables have been purchased and all residents, including R14, R30, R66, R45, R8, R7, R62, R89, R18, R40 will be seated at individual tables with the capacity of four. Resident R89 & R18 have been interviewed and are once again seated together in dining room per their preference. Clinical managers were instructed on December 22nd, 2011 on current issues regarding staff to resident interactions in dining room. Staffing and resident interactions have been being monitored in the dining room by nursing managers and that staff are educated as needed to ensure this problem is prevented and residents dignity and respect are maintained. Policy and Procedure on Meals-Preparing and Serving was amended to include proper staff and resident interaction to promote dignified dining experience for residents.	1/26/12 BT

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dan Schwanke — TITLE: adm — (X6) DATE: 20 Jan 2012

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 241	Continued From page 1 of four throughout the dining room. There were nine residents (R14, R30, R66, R45, R8, R7, R62, R18 and R40) seated at this table. The residents at this table required more assistance from staff throughout meal ranging from cueing to total assistance with feeding. Four nursing assistants sat at this table assisting residents. Nursing assistant's (NA)-A, L, C, I assisted residents with feeding and were discussing other residents by room number regarding whether or not they had been assisted to the toilet, who wanted to go to bed first and indicated the amount of output one resident had from his catheter Foley, talking to other staff about their weekend plans with the upcoming Christmas Holiday. Resident's seated at this table were not involved in the staffs conversation. During an interview at 5:45 p.m. on 12/19/11 R89 stated his tablemate (R18) was moved to "that" table, and gestured towards the four long individual rectangular tables because he was requiring more assistance with eating. R89 reported "that's where they put you when you can't eat by yourself anymore." R89 stated that was not fair to his previous tablemate for him to have to move because he needed help now and stated he missed having him at his table. R89 stated their table liked to converse during meals "like we would do at home or a restaurant." During interview at 3:20 p.m. on 12/20/11 the dietary manager (DM) stated the four long individual rectangular tables had been there since she started two years ago. DM reported this made it easy for staff to assist more residents at one time and allowed for better resident conversation when everyone could see one	F 241	DON will present an inservice on Policy and Procedure on Meals-Preparing and Serving for staff on January 25, 2012. Staff that are unable to attend will be given make-up packets or educated at mini inservices held during regular shift hours. Residents individual preferences about sitting/dining arrangements will be respected when feasible. Before moving a resident from a table, residents individual preferences will be considered. Residents dining room/table accommodations will be reviewed at care conferences quarterly to ensure residents satisfaction with seating arrangements. DON or nursing designee will conduct audits of the dining room, observing conversations and interactions of CNA's and residents four times a week for one month, and then two times per week for a month and as needed on a continual basis to prevent this problem from continuing to occur in the future. The DON will summarize findings of the audits, present them to the unit managers and to the QA committee for further recommendations and changes. Date complete: February 13, 2012	

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another. DM reported the resident's who sat at this required more assistance from staff. DM reported she was not aware of how other resident's viewed the table so negatively.

During interview at 3:21 p.m. on 12/20/11 registered nurse (RN)-A reported the table was initiated because staff used to have rolling chairs in the middle to roll around to assist residents easily with meals.

During continuous dining observation from 7:45 a.m. to 9:20 a.m. on 12/21/11 there were eight resident seated at the four long individual rectangular tables who required assistance from staff at meal time. NA- B and F were conversing amongst each other while assisting residents with their meal. The staff were observed leaning forward around the resident while eating and were discussing how they slept the previous night, complaining how early they had to wake up, staff were conversing with each other about the second jobs they had other than at the facility and how long they have worked there and what they do. NA- A and D were discussing workloads with each other for the day. At 9:00 a.m. NA-D was seated between two residents who she was supposed to be assisting with eating and started to document in the food intake book. R40 was done eating at 8:55 a.m. R40 looked around for staff to assist him back to his room but staff were assisting other residents who required more assistance. R40 was assisted to back to his room at 9:15 a.m.

During interview at 8:50 a.m. on 12/21/11 NA-B reported the facility had the tables set up in the dining room so "we can separate the dependent

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F 241	Continued From page 3 residents, from the independent residents." NA- B stated at one point they were going to put up a wall so the residents who needed assistance were completely separated. NA-B stated the residents who needed more assistance should be not be separated from the other residents unless they needed a quiet environment to eat and reported this was not the case with the residents who were placed at this table. During interview at 9:30 a.m. on 12/21/11 R40 reported he was able to feed himself but he was placed at the "long tables, so they can watch me." R40 stated sometimes it takes them 30-45 minutes to wheel him back to his room after meals and reported today it took them 25 minutes after I was done, and reported "when two of them were just standing around." During continuous dining observation from 12:21 p.m. to 12:50 p.m. on 12/21/11 eight residents were seated at the four long individual rectangular tables who required assistance from staff at meal time. NA-A, B, C, and D were assisting residents at this table. NA-F entered the dining room at 12:22 p.m., stood behind R66 seated at the table and conversed with a with NA-A seated across the table assisting R62. NA-A discussed with NA-F that room 161's family wanted his bath on a different day. NA-A continued to discuss room 161's bath day with NA-F across the table while eight residents were eating. Some resident's stopped eating and waited for the conversation to end, others appeared as if this were the daily culture of staff discussing such matters at meal times. At 12:23 p.m. NA-F walked over to NA-A and stood with her back closely to R40. R40 stopped eating,	F 241		

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looked up at NA-F's back and shook his head and appeared annoyed. At 12:36 p.m. NA-D sat at the table between two residents who required cueing to eat and documented in the food intake book. At 12:41 p.m. NA-C and NA-D, who were assisting residents at the table in the nook, discussed residents who had a snack that morning and missed documentation in the book so that NA-D could chart their intake at that time. NA-D was leaning forward in front of the residents next to her to see what their tablemate's had consumed at that time. NA-D asked NA-F how much R62 had to eat from across the table and were speculating how much they thought she would eat the rest of the meal. At 12:44 p.m. NA-C started laughing with NA-D at the table after she walked past her with nothing being said, and looked toward NA-B who asked why she rolled her eyes at her, NA-D laughed and asked "why does it matter?" Resident's were not involved in the staff conversation or the inside joke. R40 looked toward the aides confused on what was going on, all other residents ignored the conversation. Resident's at this table were not observed interacting or conversing with one another during any three meals observations.

During interview at 12:40 p.m. on 12/21/11 NA-D confirmed it was common practice for staff to sit at the table and complete the food intakes while residents were still eating near the end of their meal.

During interview at 3:12 a.m. on 12/21/11 director of nursing (DON) stated the tables were place in this manner to promote resident conversation with one another. DON reported several of the residents at this table were non-verbal so having

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F 241	Continued From page 5 them at a table where they could see other residents interacting was better than placing them at tables like more independent residents ate at. DON verified staff were expected to talk with resident they were assisting during the meal time. DON verified it was inappropriate for staff to be discussing workload or details of resident output during meal. DON confirmed it was not necessary for staff to record food intake during resident meals times and that could be done after. During dining observation at 8:33 a.m. on 12/21/11 NA-D asked NA-B "Can you put her bib on for me or I mean her 'clothing protector'?," referring to R30 who was seated at the table in the nook. During the meal NA-D was discussing NA-B when R30 was assisted up that morning and stated "why did you go get him up he's on my list?"	F 241		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide an ongoing program designed to meet, in accordance with the comprehensive assessment, the interests and well being of 1 of 1 residents (R64) reviewed with end stage dementia.	F 248	F 248 The Therapeutic Recreation Director will reassess (R64) with the revised Memory Care Therapeutic Recreation Assessment that reflects her late stages dementia and activities she is currently offered to her in relation to her past leisure preferences and experiences. A care plan will be developed to address the assistance staff will need to provide in order for her achieve her optimal level of participation or engagement in one to one visits. A revised daily programming guide will have 2 scheduled times for sensory stimulation to be offered and implemented by activity staff to meet the sensory needs for residents with late stages dementia	2-1-12

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F 248	Continued From page 6 Findings include: Resident R64 was not provided assistance with or encouraged to participate in activities that would meet her identified abilities and needs. Resident R64 had multiple diagnoses including Alzheimer's disease, vascular dementia, and late effect motor vehicle accident. According to the MDS (Minimum Data Set) assessment, R64 was non-verbal, hard of hearing and had decreased vision. According to the MDS, R64's activity participation was limited. R64's care plan dated 4/8/10 identified a goal to participate as able with 1:1 visits and small groups. During an interview conducted on 12/20/11 at 9:50 a.m., R64's family member stated R64 rarely participated in activities. The family member further stated "Most of the things they do she can't do very well but she does watch tv and Lawrence Welk. The things they do are above her abilities any more." R64's family member further indicated there really aren't activities available for residents with end stage dementia. Observations on 12/19/11 from 4:30 p.m. until 8:00 p.m., 12/20/11 from 8:00 a.m. until 9:30 a.m., and 12/21/11 from 7:00 a.m. until 10:00 a.m. revealed no activities were provided for resident's with end stage dementia, or those resident's who were unable to actively participate in activities. This included R64. The only activity R64 was observed to participate in were walks with her family member. Interview with the activity director and program coordinator on 12/20/11 at 3:45 p.m. indicated the posted schedule on the unit was for resident's with middle stage dementia or those resident's able to actively engage in the	F 248	All residents residing on Rosewood Memory Care will have individual revised activity attendance charting forms. Activity staff will document the length of time an individual was engaged in a group activity or one to one visit with sensory stimulation, what type of sensory stimulation was provided and how the resident participated in the activity or visit. Activities department staff training was held on January 11, 2012 to address documentation on sensory stimulation. Summary of training and attendees was given to HR for personal files. Staff not in attendance were given individual training. Through on going quarterly assessments and change of condition assessments, BIMS and Brief Cognitive Rating Scale assessments, residents residing on Rosewood Memory Care cognitive status' will be monitored. Given the results, the facility will address decline in cognitive status within the care plan to include residents' problem, goal and intervention in relation to past and current leisure preferences. The TR Director will monitor the effectiveness of the daily programming guide through general staff observations at random 3 times weekly. Audits to include but not limited to: Activity documentation audit at random 3 times weekly on 3 residents residing on Rosewood Memory Care. Comprehensive care plan worksheet audits will be completed on residents residing on Rosewood unit 4 times monthly. TR director will conduct audits or other designee as assigned to ensure a systematic correction is in place. Date Complete: February 1, 2012	

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activity. She further indicated there was no specific calendar of activities for those resident's unable to actively engage in activities.

Review of the activity calendars which recorded participation with the program coordinator on 12/20 at 3:00 p.m. indicated "We record every resident's activities on a worksheet so we can track what we do with them and what they're doing." However, review of the calendars for R64 indicated daily walks with her family and identified other activities with codes. Although the activity was documented on the calendar, there is no indication of resident participation in the activity or amount of time spent engaged in the activity. Review of the therapeutic recreation notes with the program coordinator confirmed the activity was not accurately reflected in the notes. There was no indication of what the activity was, the length of the activity, or the amount of time the resident spent participating in the event. On 12/21/11 at 3:25 p.m. the activity coordinator indicated "we didn't think it mattered what it was so it just says sensory but not specifically what was offered. The time's not documented. Sens (sensory stimulation) is documented on the calendar but doesn't say specifically what was done or how long."

Interview with the activity director at 3:45 p.m. on 12/20/11 indicated they try and work with resident tolerance and what their interests are. She further indicated "When we look at people with middle stages (of dementia, those resident's that are able to more actively engage in activities) we've worked with individuals to see if they will engage a little longer so it is something we've tried with resident's but it's more with the behavioral

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F 248	Continued From page 8 resident." When interviewed again on 12/21/11 at 2:15 p.m. the activity director indicated she was unable to find any other information related to activity assessment or documentation of programming/attendance.	F 248		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and	F 272	F272 Facility failed to comprehensively assess for all relevant factors related to: pressure ulcers for 1 resident (R18) and therapeutic activities for 1 resident (R64) with end stage dementia. Resident R18 had a complete comprehensive assessment done regarding wound care, including body audit, tissue tolerance, and braden scale. Wound care protocols were started including dressings, nutritional supplements, and 1½ hour repositioning. MD was notified of pressure ulcers. Documentation on December 19th, 2011 was noted in error to have a pressure ulcer at five by five centimeters this was actually 0.5 cm by 0.5 centimeters. RN managers were educated on comprehensive assessment completion issues on December 27th, 2011 and are monitoring assessment and education nursing as issues arise. DON will present an inservice on Policy and Procedure on Prevention & Treatment of Skin Breakdown and wound protocols on January 25, 2012 to staff. Staff who are unable to attend will be given make-up packets or educated at mini inservices held during regular shift hours.	

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F 272	Continued From page 9 Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess for all relevant factors related to: Pressure ulcers for 1 of 1 residents (R18) and therapeutic activities for 1 of 1 resident (R64) reviewed with end stage dementia. Findings include: Resident 18 (R18) did not receive a complete and timely comprehensive assessment or interventions that prevented the development and/or worsening of pressure ulcers. R18, originally admitted 8/2011, had diagnoses that included quadriplegia related to a spinal cord injury, spasticity, psychosis, recent pneumonia and delirium. The most recent full minimum data set (MDS), admission dated 8/26/11 identified R18 with cognitive independence, no sign/symptoms of delirium or behaviors, extensive assistance of two staff for bed mobility and transfers and most activities of daily living (ADL's). The MDS noted functional range of motion limitations in both upper and lower extremities, usual bowel incontinence and no open areas were noted.	F 272	All residents admitted or readmitted will be recorded in a log and audited by nursing designee for prompt and accurate completion of comprehensive assessments and care plan implementation for 2 months. All residents with current pressure areas will be reviewed for complete and accurate comprehensive assessments of skin risk factors. Comprehensive assessments of skin risk factors will be audited randomly to include 12 residents weekly for 3 weeks; then 6 residents weekly for 3 weeks and on an ongoing basis as needed to ensure a systematic correction is in place. The DON will summarize findings of the audits, present them to the unit managers and to the QA committee for further recommendations and changes. Date complete February 13, 2012	

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F 272	Continued From page 10 The care area assessment (CAA) summary from the admission MDS (8/26/11) noted R18 was at risk for pressure ulcers related to immobility from diagnosis, extensive assistance for mobility and hygiene and other ADL's. Every two hour repositioning was determined from tissue tolerance was noted as was intact skin at that time. R18 was recently hospitalized on three occasions for medical issues related to delirium and lethargy with possible medication interactions and pneumonia. Hospitalizations were from 11/26/11 to 12/3/11, 12/5/11 to 12/8/11 and 12/10/11 to 12/14/11. Current facility assessment policy for re-admission from each hospitalization required completion of a body audit form, tissue tolerance and re-admission care plan. The re-admission body audit dated 12/3/11 identified an old scar over the sacrum/coccyx area, but no open areas were noted and the care plan continued every two hour repositioning. The re-admission body audit dated 12/8/11 noted a circle and the code (8) for a pressure ulcer on the diagram located over the sacrum/coccyx; however, the narrative portion of the body audit noted there were no problems or pressure ulcers and no interventions were included on the care plan dated 12/8/11. The tissue tolerance also completed on 12/8/11 by the same nurse was incomplete but noted skin color was normal after two hours sitting and while in bed. The re-admission body audit from the 12/14/11 readmission, could not be initially located in the records; the admission flow sheet record had a blank space with no signature for completion of	F 272		

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F 272	Continued From page 11 the body audit that date and the re-admission care plan was not redone, but carried over from the 12/8/11 care plan. Further search by nursing staff revealed two additional body audit forms. One audit form noted open areas on the coccyx/sacrum/buttocks but was not dated or signed; the other audit located was signed and dated 12/14/11 but no open areas on the buttocks area were noted. The narrative 24 hour observation charting and nurses notes reviewed did not identify the presence of a pressure ulcer until 6:14 a.m. on 12/18/11 when three separate pressure ulcers were discovered and noted to be stage one, with no drainage. Two of the ulcers were one by one centimeter (cm.) and one was noted to be three by three cm., barrier creme was applied and R18 was turned to the side. Dressing and cleansing treatment were started later on 12/18/11. A wound care flow sheet was started on 12/19/11 and the pressure ulcers were noted at one by one cm. for two of the ulcers located on the lower and mid buttocks, and one at five by five centimeters on the coccyx. The flow sheet did not identify the stage of the ulcers. The unit nurse manager (RN-C) verified on 1:30 p.m. on 12/21/11 she thought R18 returned from the hospital on 12/8/11 without any pressure ulcers and was not aware of the body audit from the 12/8/11 nursing home readmission that identified a pressure ulcer at that time. RN-C also reported the licensed practical nurse (LPN) that completed that readmission no longer worked at the facility and verified the LPN should have followed facility policy and initiated charting on the	F 272		

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F 272	Continued From page 12 pressure ulcer, communicated the information to the nurse manager so the complete assessment, wound care flow sheet, and treatment orders would have been requested/started at that time. RN-C could not initially locate any body audit from the readmission to the facility on 12/14/11 and discovered the flow sheet for it's completion had not been signed off by staff. RN-C verified R18 currently had three separate stage two pressure ulcers on the coccyx, lower and middle buttocks areas and interventions had been started including cleansing/dressings, nutritional supplements and one hour repositioning. The director of nursing (DON) reported during interview at 9:56 a.m. on 12/22/11 she had reviewed the record and verified there was some hospital record charting that noted at least one pressure ulcer (stage one) on 12/11/11. The DON also reported the hospital transfer information did not include information on the status of any pressure ulcers and the DON was unable to contact the LPN that did the readmission on 12/8/11 to obtain any further information. A copy of the hospital charting was requested at that time but was not provided by the completion of the survey. R64 was not comprehensively assessed for her activity needs. Resident R64, who was on hospice and had end stage dementia, did not receive a comprehensive assessment for activity preference and participation. Resident had multiple diagnoses including Alzheimer's and vascular dementia. According to her MDS (Minimum Data Set) assessment dated 11/5/11 R64 did not speak, was hard of hearing and had visual limitations so many of the required interviews were conducted through a family	F 272	The Therapeutic Recreation Director will reassess (R64) with revised Memory Care Therapeutic Recreation Assessment that reflects her late stages dementia and activities she is currently offered to her in relation to her past leisure preferences and experiences. A care plan will be developed to address the assistance staff will need to provide in order for her achieve her optimal level of participation or engagement in one to one visits. A revised daily programming guide will have 2 scheduled times for sensory stimulation to be offered and implanted by activity staff to	

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F 272	Continued From page 13 member. The MDS dated 11/5/11 was an annual assessment and identified the problem area of activities. The problem was triggered due to R64's indication of depression/anxiety, physical disability, cognitive deficits, chronic health conditions, and limited time/energy. According to the documented activity assessment, R64 "triggered for activities related to her Alzheimer's disease and vascular dementia. She does not have speech. Therefore, she is unable to expressive herself or her wants. Her vision is highly impaired. This limits her activity participation even to things such as; reading the newspaper." Review of progress notes for this time period revealed no other activity assessments had been completed. Although an "annual interview" was completed with a family member on 10/31/11 which identified activities of interest for R64 these areas were not included in the annual assessment. The last date of completion on the past interest activity assessment was 7/9/09. The assessment failed to include R64's physical and mental limitations and how they would impact her activity participation and what adjustments would be made to ensure as much participation as possible. Further, there was no information in the assessment to identify which activities was able to participate in, how long her ability to participate was or how she demonstrated interest/what her response was to the activity. Interview with the activity director on 12/21/11 at 2:15 p.m. revealed she had no other information related to activity assessments for R64.	F 272	meet the sensory needs for residents with late stages dementia All residents residing on Rosewood Memory Care will have individual revised activity attendance charting forms. Activity staff will document the length of time an individual was engaged in an activity or one to one visit with sensory stimulation, what type of sensory stimulation was provided and how the resident participated in the activity or visit. Activities department staff training was held on Jan 11, 2012 to address documentation on sensory stimulation. Summary of training and attendees was given to HR for personal files. Staff not in attendance were given individual training. Through on going quarterly assessments and change of condition assessments, BIMS and Brief Cognitive Rating Scale assessments, residents residing on Rosewood Memory Care cognitive status' will be monitored. Given the results, the facility will address decline in cognitive status within the care plan to include residents' problem, goal and intervention in relation to past and current leisure preferences. The facility will monitor the effectiveness of the daily programming guide through general staff observations at random 3 times weekly. Audits to include but not limited to: Activity documentation audit at random 3 times weekly on 3 residents residing on Rosewood Memory Care. Comprehensive care plan worksheet audits will be completed on residents residing on Rosewood unit 4 times monthly. TR director will conduct audits or other designee as assigned. Date completed: February 1, 2012	
F 276	483.20(c) QUARTERLY ASSESSMENT AT	F 276		

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F 276 SS=D	Continued From page 14 LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively re-assess for all relevant factors related to wheelchair positioning for 1 of 2 residents (R61) reviewed in the sample. Findings include: R61 was not re-assessed for wheelchair positioning after being identified with leaning while in the wheelchair. Resident R61 had multiple diagnoses including Alzheimer's disease, bone and cartilage disease, and TIA's (Transient ischemic attacks). According to physician orders dated 11/14/11 R61's rehabilitation potential was good. According to the care plan for mobility dated 3/23/10 and provided by the facility as current, R61 had no identified problems with positioning. On 12/19/11 during the supper meal observation, R61 was observed to lean to the right throughout the entire meal. Her arm was dangling at the side of the wheelchair with her hand and wrist visibly deep red to purple in color. Review of progress notes revealed a note dated 11/8/11 indicating the resident was leaning to the right side in the wheelchair and got her right index and middle	F 276	F276 Facility failed to comprehensively reassess for all relevant factors related to wheelchair positioning for 1 resident (R61). Resident R61 was evaluated by occupational therapy for wheelchair positioning and a new tray for wheelchair was purchased per Occupational Therapy recommendations and a new wheelchair was provided. All residents will have wheelchair positioning reassessed quarterly and on significant changes on Safety Risk Data Collection sheet to ensure systematic compliance. RN Managers were educated on comprehensively assessing residents on wheel chair positioning for an on going basis on 12-27-2011 and have been observing wheel chair positioning of residents and educating staff when issues arise. DON or nursing designee will present an inservice on Policy and Procedure of Use of Wheelchair and Proper Positioning in Wheelchair on January 25, 2012 to staff. Staff not able to attend will be given make-up packets or educated at mini inservices scheduled during regular shift hours. DON or nursing designee will monitor this problem by auditing residents positioning in wheelchair to include 12 residents weekly for one month and then to include 6 residents weekly for one month if compliance is noted and as needed on a continual basis to prevent this problem in the future. The DON will summarize findings of the audits, present them to the unit managers and to the QA committee for further recommendations and changes. Date complete: February 13, 2012	

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F 276	Continued From page 15 fingers caught in between the brake and the wheelchair tire. Review of the most recent MDS, a quarterly MDS dated 12/5/11 identified no issues with positioning. Although staff was aware of R61's leaning in her wheelchair since 11/8/11, there was no re-assessment of her positioning needs while in the wheelchair. Interview on 12/20/11 at 8:50 a.m. with the clinical manager revealed she was aware of R61's leaning while in the wheelchair "I've seen her leaning but with repositioning she's better. It was kind of both sides though. I haven't heard anything about her leaning any more than normal. I would think if I had made an OT (occupational therapy) referral it would be in her chart." Interview with the PTA (physical therapy assistant) and PT (physical therapist) on 12/21/11 at 10:20 a.m. and 11:20 a.m. respectively revealed they had not received a positioning referral for R61 so no re-assessment for positioning had been completed by therapy staff.	F 276		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of	F 278	F278 Facility failed to perform an accurate comprehensive assessment that resulted in appropriate treatment and services to restore as much normal bladder function as possible to 1 resident (R 13). Resident R13 was seen by primary MD regarding incontinence issues, MD is addressing issue of incontinence and family conference has been set up to discuss surgical options. Nursing has set up a training program to educate resident to do Kegel exercises.	

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F 278	Continued From page 16 that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to perform an accurate comprehensive assessment that resulted in appropriate treatment and services to restore as much normal bladder function as possible for 1 of 1 residents (R13) in the sample. Findings include: Resident 13 (R13) comprehensive assessment related to bladder function did not accurately address all relevant individualized factors involved and did not result in appropriate interventions in the plan of care to maximize bladder function and reduce incidence of urinary incontinence. R13 had diagnoses that included diabetes, urinary incontinence, arthritis, hypertension and	F 278	RN managers were educated on comprehensive assessment completion on bowel and bladder assessments on 12-27-2011 and are addressing new issues if they arise. Residents Bowel and Bladder Assessment form has been updated to address current status. Bowel and Bladder Quarterly Review form has been updated and form has been implemented for MD notification regarding resident incontinence type and concerns. DON or nursing designee will hold inservice on January 25, 2012 regarding Bowel and Bladder Assessments and changes made. Staff not able to attend will be given make-up packets or be educated at mini inservices scheduled during regular shift hours. DON or nursing designee will conduct audits of bowel and bladder assessments and care plans to include 12 residents weekly for 1 month; then to include 6 residents weekly for 1 month if compliance is noted and as needed to ensure that diagnosis is noted and MD is notified of incontinence and involved in incontinence plan to ensure a systematic process is in place. The DON will summarize findings of the audits, present them to the unit managers and to the QA committee for further recommendations and changes. Date completed: February 13, 2012	

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heart disease.
The admission minimum data set (MDS) dated 7/18/11 identified R13 with cognitive independence, some indicators of depressed mood, no indicators of behaviors or delirium, extensive assistance for mobility, walking and toilet use, unsteady balance and occasional urinary incontinence with no toilet program indicated.
R13 had improved in some activities of daily living and the 10/8/11 quarterly MDS noted independence in mobility and toilet use, but still occasional urinary incontinence.

The care area assessment (CAA) summary from the 7/18/11 MDS identified factors that affected incontinence including pain and diuretic use but did not identify or address the type of incontinence or that she had any episodes of incontinence since admission and the care plan was to be developed to maintain current continence. The current care plan dated 7/19/11 did not identify any problems or any interventions for bladder function/incontinence.

The bladder assessment dated 7/18/11 did not identify all relevant symptoms affecting bladder elimination patterns including leaking, dribbling or problems with standing up. Some of the medications used were not identified and a treatment plan not developed. A bladder record completed 9/2/11 to 9/8/11 for the quarterly review of bladder function just noted, [Independent] for all the days recorded and no changes recommended to the initial assessment.

R13 verified during interview at 4:50 p.m. on 12/19/11 every time she stood at the bedside or

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F 278	Continued From page 18 to get on to the toilet she leaked urine on to the floor. The room had a faint odor of urine from the carpet near the bedside. R13 further stated, "Whenever I stand up it runs, there is usually a puddle by the bed and on the toilet floor. I clean it it myself. I tried to wear briefs, but they itch me. Is there any surgery that would help me? The doctor changes my pills but they don't make any difference. They [staff] told me to try to hold it a couple hours before I go. I can take myself to the toilet; it leaks several times every day." The unit nurse manager (RN-A) verified at 9:00 a.m. on 12/22/11 R13 did still have incontinence and the bladder assessment completed and care area assessment summary were not accurate or complete and should have included a review of relevant factors and care plan components that addressed the incontinence developed.	F 278		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to follow the care plan for 1 of 3 residents in the sample (R35) reviewed who experienced falls in the facility and 1 of 1 resident (R58) in the sample on dialysis who was on a fluid restriction. Findings include:	F 282	F282 Facility failed to follow the care plan for 1 resident (R35) reviewed who experienced falls in the facility and 1 resident (R58) who on dialysis who was on a fluid restriction. Resident R 35 is care planned for tabs alarm in wheelchair and bed, non-slip material to wheelchair seat, 15 minute checks while out of bed, motion sensor to door frame to alert staff when resident is entering room to prevent falls. Resident was checked on January 18, 2012 to ensure all interventions were in place and working correctly. RN managers were educated on 12-27-2011 on issues of following care plan regarding	

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F 282	Continued From page 19 R35 experienced a total of four falls in the facility from 10/12/11 through 12/2/11. R35's falls dated 11/25/11 and 12/2/11 did not have assessed interventions in place to reduce the risk of subsequent falls. R35's care plan, dated 10/4/11, directed staff to not leave the resident in her room alone. The care plan was updated on 11/16/11 to include a motion sensor placed at the room doorway to alert staff of her entering her room. Review of the incident report dated 11/25/11 established R35 experienced an unwitnessed fall in her room. The incident report stated that the resident's TABs alarm was sounding, however, it did not note if the doorway motion sensor was in place or alarming, or why R35 was in her room alone. An incident report dated 12/2/11 noted that R35 experienced another unwitnessed fall in her room. The report noted that the TABs alarm was not sounding, and the doorway motion sensor was not mentioned. The unit manager (RN-B) stated on 12/21/11 at 7:15 a.m. that R35 was not to be left alone in her room, and the doorway motion sensor was to be in place to alert staff when she entered her room by herself. She said that she was not sure if the motion sensor was in place near the door at the time of the falls. She said that it should have been in place so staff would know R35 was in her room alone, but nowhere in the incident reports did it note that it was. She acknowledged that if the doorway motion sensor was in place, it would have alerted staff to R35's whereabouts, and possibly prevented the falls which occurred while she was alone in her room.	F 282	falls and fluid restrictions and are monitoring these and educating nursing as issues arise. DON or nursing designee will conduct staff inservice on Policy for Incident & Accident Reporting on January 25, 2012. Staff not able to attend will be given make-up packets or educated at mini inservices held during regular shift hours. Residents care plans and care sheets will be audited to ensure that these match and interventions will be audited to include 12 resident charts weekly for 1 month; then to include 6 resident charts weekly for 1 month if compliance is noted and as needed on a continual basis to ensure that interventions to prevent falls are in place and care planned. Resident R58 was care planned for 1500ml fluid restrictions per MD orders. DON or nursing designee will conduct staff inservice on Policy & Procedure on Intake and Output on January 25, 2012. Staff not able to attend will be given make-up packets or educated at mini inservices held during regular shift hours. RN managers were educated on fluid intake monitoring on 12-27-2011 and have provided education to staff when needed. Fluid intake for residents on fluid restrictions will be audited three times a week for one month then one time a week for a month to ensure a systematic improvement is occurring. The DON will summarize the findings of the audits to the unit managers and to the QA committee for further recommendations and changes. Date completed: February 13, 2012	

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F 282	Continued From page 20 Fluid Restriction R58's care plan was not implemented to monitor for a 1500 ml fluid restriction diet. The physician ordered 1500 ml fluid restriction related to dialysis. R58 had multiple diagnoses including end stage renal disease, diabetes, and dementia. The care plan dated 1/6/11 and provided by the facility as current, identified the problem of complications related to hemodialysis and identified the intervention of a 1500 ml fluid restriction and the need for monitoring intake. R58 had a physician order for the 1500 ml fluid restriction dated 8/26/11. Review of the meal intakes for October 2011, November 2011, and December 2011 revealed inconsistent and inaccurate documentation of the fluids consumed. In October 2011 there were 93 opportunities for meal documentation and 33 opportunities were blank for the amount of fluids consumed. Review of the Intake and Output sheet for October 2011 identified 93 opportunities for intake by shift and 31 opportunities for documentation of total intake in the 24 hour period. Of 93 opportunities for shiftly documentation of intake, 48 opportunities were blank. For 24 hour total intake 31 of 31 opportunities were blank. It is unknown for the month of October 2011 if the 1500 cc fluid restriction was met for R58. Review of the November 2011 Food Consumption Record identified 90 opportunities to document meal time intake. Of those 90 opportunities there were 26 missed opportunities for documentation. Upon initial review of the Intake and Output record for November 2011, it appears to be consistently documented. However, when the amount of fluid	F 282		

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consumed at meal times is not documented, the data collected indicating total intake of fluid per shift is inaccurate. Therefore, there were 25 inaccurate fluid intake entries and a corresponding 16 intake totals that were inaccurate for November 2011. It is unclear for those 16 days in November if R58 met the physician ordered 1500 cc fluid restriction. The month of December indicated 60 opportunities for meal documentation through 12/20/11. Of those 60 opportunities, there were 20 missed opportunities for documentation of fluids consumed. Review of the Intake and Output record for December 2011 indicated of the 60 opportunities there were 26 missed opportunities and 3 inaccuracies due to incomplete documentation. R58's 1500 ml fluid restriction was not monitored through 12/20/11.

Interview with LPN-B on 12/21/11 at 1:50 p.m. indicated "To track the intake at meds I write down the intake of her supplements on the MAR (Medication Administration Record) and with med pass I use the fluids right at the table for meal time so it's counted in. That's how I remember to total up her intake at the end of the day." LPN-B verified the documentation issues with the Food Consumption Records and intake monitoring. She further indicated they would not be able to accurately reflect intake and the 1500 ml fluid restriction without the data collected from meal times.

When interviewed on 12/22/11 at 8:30 a.m. about monitoring intake and the fluid restriction for R58 the nurse manager indicated she was unaware of the issues. "It's our cart nurses responsibility at the end of the day to ask the aides what (R58)

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F 282	Continued From page 22 had for fluids and they're to document it. That's why we keep them in the MAR. There's one aide every shift that's assigned to track meals." The nurse manager further stated "It's always seemed to be a good system in the past but maybe with the new staff it's not working as well. We're going to have to brainstorm on that and see what we have to do to get a better system (for monitoring and documenting fluid intake)."	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide the necessary care and services to attain or maintain the highest practicable well-being in accordance with the comprehensive assessment and plan of care for 1 of 2 resident's (R61) reviewed for positioning and 1 of 1 (R58) resident's reviewed for fluid restrictions related to dialysis. Findings include: R61 was not provided appropriate wheelchair positioning after being identified by facility staff as leaning in the wheelchair. Resident R61 had multiple diagnoses including Alzheimer's disease,	F 309	F309 Facility failed to provide the necessary care and services to attain or maintain the highest practicable well-being in accordance with the comprehensive assessment and plan of care for 1 resident (R 61) reviewed for positioning and 1 resident (R58) reviewed for fluid restrictions related to dialysis. Resident R61 was evaluated by occupational therapy for wheelchair positioning and resident has received a new wheelchair and a new tray was recommended and has been purchased to provide for better wheelchair positioning. RN managers were educated on lack of care provided to ensure proper wheel chair positioning on 12-27-2011 and monitoring of fluids. RN managers are educating staff and addressing issues as they arise. DON or nursing designee will present an inservice on Policy and Procedure of Use of Wheelchair & Proper Positioning in Wheelchair on January 25, 2012. Staff not able to attend will be given make-up packets or educated at mini inservices held during regular shift hours. This policy was updated.	

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F 309	Continued From page 23 bone and cartilage disease, and TIA's (Transient ischemic attacks). According to physician orders dated 11/14/11 R61's rehabilitation potential was good. According to the care plan for mobility dated 3/23/10 and provided by the facility as current, R61 had no identified problems with positioning. On 12/19/11 during the supper meal observation, R61 was observed to lean to the right throughout the entire meal. Her arm was dangling at the side of the wheelchair with her hand and wrist visibly deep red to purple in color. Nursing assistant-H (NA-H) reported during interview at 6:15 p.m. he was not sure if the arm was supposed to be hanging down or supported on the chair or table. NA-H added, "If I put it up she will put it back down again." NA-H placed R61's hand and wrist on the table and it remained on the table until near the completion of the meal at 6:30 p.m. On 12/21/11 at 8:40 a.m. R61 was again observed to lean in her wheelchair. She leaned to the right with her arm off of the arm rest and her thumb hooked on the wheelchair brake. Her arm remained in that position throughout breakfast with no staff assistance until 9:15 a.m. when she was removed from the dining room by facility staff. Review of progress notes revealed a note dated 11/8/11 indicating the resident was leaning to the right side in the wheelchair and got her right index and middle fingers caught in between the brake and the wheelchair tire. A facility incident report dated 11/8/11 identified the same issue and indicated redness, swelling and bruising to her fingers from the incident. The identified action to	F 309	DON or nursing designee will audit residents positioning in wheelchair to include 12 residents weekly for 1 month; then to include 6 residents weekly for 1 month if compliance is noted and as needed on a continual basis to address the systematic issue and prevent these problems from occurring in the future. Resident R58 and all residents on fluid restrictions will have fluid intake audited three times a week for a month and then one time a week for another month and as needed on a continual basis by nursing designee. DON or nursing designee will provide inservice on Policy and Procedure of Intake and Output on January 25, 2012. Staff not able to attend will be given make-up packets or be educated at mini inservices held during regular shift hours. The DON or nursing designee will also audit mealtime food/fluid intake sheets to include 12 residents weekly for 1 month; then to include 6 residents weekly for 1 month if compliance is noted and as needed on a continual basis to ensure a systematic correction has occurred. The DON will summarize the findings of the audits, present to the unit managers and to the QA committee for further recommendations and changes. Date completed February 13, 2012	

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F 309	Continued From page 24 prevent further injury was "staff education." There was no evidence of a review for wheelchair positioning or wheelchair modification. There was no further documentation in the medical record related to R61's wheelchair positioning. On 12/21/11 at 7:50 a.m. NA-J stated to NA-K "Don't get her (R61) up too early - she gets tired and then she leans" Providing further clarification, NA-J stated that whenever R61 is tired, she leans. On 12/20/11 at 8:50 a.m., the clinical manager stated "I've seen her leaning but with repositioning she's better. It was kind of both sides though. I haven't heard anything about her leaning any more than normal I've heard that she leans sometimes but nothing serious. I would think if I had made an OT referral it would be in her chart. She was in PT in 8/11 because she's less mobile and we're trying to get her walking again - I thought I did OT (a referral) too but it looks like just PT." Interview with the physical therapist on 12/21/11 at 11:20 a.m. revealed no referral had come through for wheelchair positioning for R61. Interview with the director of nursing on 12/22/11 at 9:30 a.m. indicated "staff are taught that if they see a leaning issue they should let the nurse know so we can do something - make an OT referral or work on positioning. We have OT orders for her now." Review of the facility policy "Positioning the Resident" dated 2008 and provided by the facility as current indicated the purpose of positioning was "To promote proper body alignment."	F 309		

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Fluid Restriction

R58 did not receive consistent monitoring for the physician ordered 1500 ml fluid restriction related to dialysis. R58 had multiple diagnoses including end stage renal disease, diabetes, and dementia. The care plan dated 1/6/11 and provided by the facility as current, identified the problem of complications related to hemodialysis and identified the intervention of a 1500 ml fluid restriction and the need for monitoring intake. R58 had a physician order for the 1500 ml fluid restriction dated 8/26/11.

Review of the meal intakes for October 2011, November 2011, and December 2011 revealed inconsistent and inaccurate documentation of the fluids consumed. In October 2011 there were 93 opportunities for meal documentation and 33 opportunities were blank for the amount of fluids consumed. Review of the Intake and Output sheet for October 2011 identified 93 opportunities for intake by shift and 31 opportunities for documentation of total intake in the 24 hour period. Of 93 opportunities for shiftly documentation of intake, 48 opportunities were blank. For 24 hour total intake 31 of 31 opportunities were blank. It is unknown for the month of October 2011 if the 1500 cc fluid restriction was met for R58. Review of the November 2011 Food Consumption Record identified 90 opportunities to document meal time intake. Of those 90 opportunities there were 26 missed opportunities for documentation. Upon initial review of the Intake and Output record for November 2011, it appears to be consistently documented. However, when the amount of fluid consumed at meal times is not documented, the data collected indicating total intake of fluid per

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shift is inaccurate. Therefore, there were 25 inaccurate fluid intake entries and a corresponding 16 intake totals that were inaccurate for November 2011. It is unclear for those 16 days in November if R58 met the physician ordered 1500 cc fluid restriction. The month of December indicated 60 opportunities for meal documentation through 12/20/11. Of those 60 opportunities, there were 20 missed opportunities for documentation of fluids consumed. Review of the Intake and Output record for December 2011 indicated of the 60 opportunities there were 26 missed opportunities and 3 inaccuracies due to incomplete documentation. R58's 1500 ml fluid restriction was not monitored through 12/20/11.

Interview with LPN-B on 12/21/11 at 1:50 p.m. indicated "To track the intake at meds I write down the intake of her supplements on the MAR (Medication Administration Record) and with med pass I use the fluids right at the table for meal time so it's counted in. That's how I remember to total up her intake at the end of the day." LPN-B verified the documentation issues with the Food Consumption Records and intake monitoring. She further indicated they would not be able to accurately reflect intake and the 1500 ml fluid restriction without the data collected from meal times.

When interviewed on 12/22/11 at 8:30 a.m. about monitoring intake and the fluid restriction for R58 the nurse manager indicated she was unaware of the issues. "It's our cart nurses responsibility at the end of the day to ask the aides what (R58) had for fluids and they're to document it. That's why we keep them in the MAR. There's one aide

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F 309	Continued From page 27 every shift that's assigned to track meals." The nurse manager further stated "It's always seemed to be a good system in the past but maybe with the new staff it's not working as well. We're going to have to brainstorm on that and see what we have to do to get a better system (for monitoring and documenting fluid intake)." On 12/22/11 at 10:30 a.m. the director of nursing indicated "It's (Intake) put on the MAR so they document and obviously the meal should be documented. It's a matter of communication with the nursing assistants - having to let them know what was taken in for the shift. That's supposed to be the process." The "Intake and Output Measurement" policy provided by the facility as current, dated 2008, confirmed the process. The policy further indicated the 24 total intake is to be tallied by the night shift nurse and refer any problems to the nurse manager. The policy further indicated "If the intake and output is not adequate, notify the nurse manager, physician/GNP (geriatric nurse practitioner). Take corrective action per physician orders."	F 309		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314	F314 Facility failed to ensure that a resident who entered the facility without pressure ulcers did not develop pressure ulcers unless the individuals clinical condition demonstrated they were unavoidable; and a resident with pressure ulcers received necessary treatment and services to promote healing, prevent infection and prevent new sores from developing for 1 resident (R18).	

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F 314	Continued From page 28 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure that a resident who entered the facility without pressure ulcers did not develop pressure ulcers unless the individual's clinical condition demonstrated they were unavoidable; and a resident with pressure ulcers received necessary treatment and services to promote healing, prevent infection and prevent new sores from developing for 1 of 1 resident (R18) reviewed in the sample. Findings include: R18, who was assessed at high risk for pressure ulcers, was noted to have a pressure ulcer upon a readmission to the facility from the hospital and was not comprehensively assessed for all relevant factors at that time. In addition, interventions and necessary care and treatment was not initiated in a timely manner until 10 days after the pressure ulcer was first documented in the facility clinical record. The facility practice resulted in worsening of the pressure ulcers (three separate stage 2 ulcers) and resulted in actual harm to the resident. R18, originally admitted to the facility 8/2011, had diagnoses that included quadriplegia related to a spinal cord injury, spasticity, psychosis, recent pneumonia and delirium. The most recent full minimum data set (MDS), admission dated 8/26/11 identified R18 with cognitive independence, no sign/symptoms of	F 314	Resident R 18 had a complete comprehensive assessment done regarding wound care, including a body audit tissue tolerance, Braden scale and wound protocols were started including dressings, nutritional supplements and 1 1/2 hour repositioning. Resident was evaluated in occupational therapy regarding seating positioning. Residents care plan was updated to include pressure ulcer prevention measures. Admission/readmission body audit form was changed to include if new skin issues or pressure areas are noted to inform RN manager or charge nurse and initiate wound protocol immediately. RN managers were educated on 12-27-2011 regarding proper procedure of pressure ulcer prevention and managers have been educating staff as needed. DON or nursing designee will hold inservice on Policy and Procedure on Prevention & Treatment of Skin Breakdown on January 25, 2012. Staff not able to attend will be given make-up packets or educated at mini inservices held during regular shift hours. All residents admitted or readmitted will be recorded in a log and audited for prompt and accurate completion of comprehensive assessments and careplan implementation for 2 months. All residents with current pressure areas will be reviewed for complete and accurate comprehensive assessments of skin risk factors. Comprehensive assessments of skin risk factors will also be audited randomly to include 12 residents weekly for 1 month; then to include 6 residents weekly for 1 month if compliance is noted and then on an ongoing basis as needed to ensure the systematic error has been corrected. DON will summarize finding	

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F 314	Continued From page 29 delirium or behaviors, extensive assistance of two staff for bed mobility and transfers and most activities of daily living (ADL's). The MDS noted functional range of motion limitations in both upper and lower extremities, usual bowel incontinence and no open areas were noted. The care area assessment (CAA) summary from the admission MDS (8/26/11) noted R18 was at risk for pressure ulcers related to immobility from diagnosis, extensive assistance for mobility and hygiene and other ADL's. Every two hour repositioning was determined from this tissue tolerance and at this time the skin was noted to be intact. The temporary care plan dated 12/8/11 was the currrent working care plan for R18. The care plan noted every two hour repositioning, elevate heels and wheelchair cushion. There was no change in pressure ulcer interventions from the previous temporary care plan dated 12/3/11. A complete care plan had not been developed at the time the pressure ulcers were noted again on 12/18/11. R18 was recently hospitalized on three occasions for medical issues related to delirium and lethargy with possible medication interactions and pneumonia. Hospitalizations were from 11/26/11 to 12/3/11, 12/5/11 to 12/8/11 and 12/10/11 to 12/14/11. The facility re-admission body audit dated 12/3/11 identified an old scar over the sacrum/coccyx area, but no open areas were noted and the care plan continued every two hour repositioning. The re-admission body audit dated 12/8/11 noted a circle and the code (8) for a pressure ulcer on the	F 314	of audits present them to unit managers and to the QA committee for further recommendations and changes. Date completed: February 13, 2012	

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diagram located over the sacrum/coccyx; however, the narrative portion of the body audit noted there were no problems or pressure ulcers and no interventions were included on the care plan dated 12/8/11. The tissue tolerance also completed by the same nurse on 12/8/11 was incomplete but noted skin color was normal after two hours sitting and while in bed.

The re-admission body audit from the 12/14/11 readmission, could not be initially located in the records; the admission flow sheet record had a blank space with no signature for completion of the body audit that date and the re-admission care plan was not redone but carried over from the 12/8/11 care plan.
Another flow sheet located noted the statement: [Needs body audit yet,} on 12/14/11. A notation on 12/15/11 read: [Body audit done, cream to buttocks.]

Further search by nursing staff revealed two additional body audit forms. One audit form noted open areas on the coccyx/sacrum/buttocks but was not dated or signed; the other audit located was signed and dated 12/14/11 but no open areas on the buttocks area were noted.

The narrative 24 hour observation charting and nurses notes reviewed did not identify the presence of a pressure ulcer until 6:14 a.m. on 12/18/11 when three separate pressure ulcers were discovered and noted to be stage one, with no drainage. Two of the ulcers were one by one centimeter (cm.) and one was noted to be three by three cm., barrier creme was applied and R18 was turned to the side.

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Dressing and cleansing treatment were started later on 12/18/11. A wound care flow sheet was started on 12/19/11 and the pressure ulcers were measured at one by one cm. for two separate ulcers located on the lower and mid buttocks, and one ulcer measuring five by five centimeters on the coccyx. The wound flow sheet did not identify the stage of the ulcers.
The record did not contain any referrals or reassessment by Occupational Therapy after the electric wheelchair had been discontinued and the manual chair utilized after 12/8/11 was an extra wide chair with a gel pressure cushion.

R18 reported during interview at 7:40 a.m. on 12/21/11 he had severe spasms the night before while in bed and had asked to sit up in the wheel chair. R18 also stated he had been using an electric wheelchair earlier in December, but he ran into things with it and it was taken away and replaced by the manual chair. R18 stated some times he sat up in the chair all day and staff did not reposition him unless he went to bed or toilet. R18 reported the pressure ulcers he has got worse from the electric wheelchair he used and had, "just started as a pimple." R18 was noted to be sitting in the wheelchair on a gel pressure reduction cushion; however, his hips were over to the left side of the chair and his weight unevenly distributed on the right buttocks.

Nursing assistant-G (NA-G) reported at 9:35 a.m. R18 was repositioned every hour and a half and earlier that morning his pressure ulcers did not have any dressing on and were noted to be bleeding when cares were done, but the nurse had replaced the dressings after notification they had come off. Because the dressing had just

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been replaced and were designed to last three days, the pressure ulcers were not observed by surveyor during the survey.

The tissue tolerance that was completed on 12/18/11 and the current nursing assistant care sheets directed that repositioning be done with assist of two staff each hour.

The unit nurse manager (RN-C) verified on 1:30 p.m. on 12/21/11 she thought R18 returned from the hospital on 12/8/11 without any pressure ulcers and was not aware of the body audit from the 12/8/11 nursing home readmission that identified a pressure ulcer at that time. RN-C also reported the licensed practical nurse (LPN) that completed that readmission no longer worked at the facility and verified the LPN should have followed facility policy and initiated charting on the pressure ulcer, communicated the information to the nurse manager so the complete assessment, wound care flow sheet, and treatment orders would have been requested/started at that time. RN-C could not initially locate any body audit from the readmission to the facility on 12/14/11 and discovered the flow sheet for it's completion had not been signed off by staff. RN-C verified R18 currently had three separate stage two pressure ulcers on the coccyx (outer skin layers not intact), lower and middle buttocks areas and interventions had been started including cleansing/dressings(Allevyn), nutritional supplements and one hour repositioning.

The director of nursing (DON) reported during interview at 9:56 a.m. on 12/22/11 she had reviewed the record and verified there was some hospital record charting that noted at least one

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F 314	Continued From page 33 pressure ulcer (stage one) on 12/11/11. The DON also reported the hospital transfer information did not include information on the status of any pressure ulcers and the DON was unable to contact the LPN that did the readmission on 12/8/11 to obtain any further information. A copy of the hospital charting was requested at that time but was not provided by the completion of the survey.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide appropriate treatment and services to restore as much normal bladder function as possible for 1 of 1 residents (R13) in the sample. Findings include: Resident 13's (R13) comprehensive assessment related to bladder function was not accurate and appropriate interventions were not developed in the plan of care to maximize bladder function and	F 315	F315 Facility failed to provide appropriate treatment and services to restore as much normal bladder function as possible for 1 resident (R13). Resident R13 had her bowel and bladder assessments redone on January 18, 2012. New 7 day voiding pattern was done. Resident R13's MD saw resident and a family conference has been set up to discuss surgical interventions for incontinence. Diagnosis has been obtained from resident R13's MD. Nursing has educated resident on Kegel exercises to prevent further decline and possibly improve bladder function. Resident R13's care plan was updated with treatment plan for maximization of bladder function. Bowel and bladder assessment form has been updated and form was implemented for MD notification regarding resident incontinence type and concerns. RN managers were educated on 12-27-2011 regarding complete and thorough bowel and bladder assessments and have been reviewing bowel and bladder assessments and educating nursing on an ongoing basis as needed.	

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TALAHI CARE CENTER	1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304

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F 315	Continued From page 34 reduce the incidence of urinary incontinence. R13 had diagnoses that included diabetes, urinary incontinence, arthritis, hypertension and heart disease. The admission minimum data set (MDS) dated 7/18/11 identified R13 with cognitive independence, some indicators of depressed mood, no indicators of behaviors or delirium, extensive assistance for mobility, walking and toilet use, unsteady balance and occasional urinary incontinence with no toilet program indicated. R13 had improved in some activities of daily living and the 10/8/11 quarterly MDS noted independence in mobility and toilet use, but still occasional urinary incontinence. The care area assessment (CAA) summary from the 7/18/11 MDS identified factors that affected incontinence including pain and diuretic use but did not identify or address the type of incontinence or that she had any episodes of incontinence since admission and the care plan was to be developed to maintain current continence. The bladder assessment dated 7/18/11 did not identify all relevant symptoms affecting bladder elimination patterns or develop a treatment plan. The current care plan dated 7/19/11 did not identify any problems or any interventions for bladder function/incontinence. The primary physician's notes dated 10/26/11 noted there had been some previous involvement of a urologist for the incontinence; however, no treatments had been helpful and the medications used developed adverse reactions with	F 315	DON or nursing designee will hold inservice on January 25, 2012 regarding Bowel and Bladder assessments and changes made. Staff not able to attend will be given make-up packets or educated at mini inservices held during regular shift hours. Nursing staff were educated on importance of completing documentation accurately. DON or nursing designee will conduct audits of bowel and bladder assessments, voiding diary, and care plans to include 12 residents weekly for 1 month; then to include 6 residents weekly for 1 month if compliance is noted and then on an ongoing basis as needed to address the systematic issue and make corrections as needed and prevent this problem from occurring again in the future. The DON will summarize the findings of the audits, present them to the unit managers and to the QA committee for further recommendations and changes. Date completed: February 13, 2012	

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F 315	Continued From page 35	F 315		

hallucinations and R13 continued to have nocturia. The urinary medication (Sanctura) was discontinued and urinary symptoms were to be re-evaluated.

R13 verified during interview at 4:50 p.m. on 12/19/11 every time she stood at the bedside or to get on to the toilet she leaked urine on to the floor. The room had a faint odor of urine from the carpet near the bedside. R13 further stated, "Whenever I stand up it runs, there is usually a puddle by the bed and on the toilet floor. I clean it it myself. I tried to wear briefs, but they itch me. Is there any surgery that would help me? The doctor changes my pills but they don't make any difference. They [staff] told me to try to hold it a couple hours before I go. I can take myself to the toilet; it leaks several times every day." R13 also expressed concerns related to the recent transfer to a semi-private room and that she was spending so much time in the bathroom/toilet it seemed to be upsetting to the roommate. R13 questioned whether the physician would authorize a private room because of the urinary issues she was having.

Nursing assistant-G (NA-G) verified during interview at 9:37 a.m. on 12/21/11 they aides don't give any assistance to R13 and the resident was able to take herself to the toilet and was not sure, but did not think R13 was incontinent very much and was not aware R13 was cleaning up urine puddles on the floor.

The unit nurse manager (RN-A) verified at 9:00 a.m. on 12/22/11 she was not sure if there were any recommendations from any urology consult or if there was any consultation record of R13

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F 315	Continued From page 36 with a gynecologist for any surgical interventions for the incontinence. No referrals had been made to therapy for exercises to reduce incontinence. RN-A did verify R13 did still have incontinence and there should be care plan components that addressed the incontinence in different sections of the care plan. A review of the care plan, however, did not identify any section or interventions that were appropriate for the bladder incontinence. RN-A stated she talked to R13 about incontinence exercises but the resident did not seem to understand them and it was, "hit or miss." RN-A verified the urinary incontinence should have been addressed more on the comprehensive assessment, CAA and interventions developed for the care plan and any referrals to other specialists would have to be initiated from the primary physician.	F 315		
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 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 record review, the facility failed to provide assessed interventions to reduce the risk of falls for 1 of 3 residents in the sample (R35) who was determined to be at risk for falls.	F 323	F323 Facility failed to provide assessed interventions to reduce the risk for falls for 1 resident (R35) Resident (R35) care plan reviewed and is to have tabs alarm to wheelchair and bed, non-slip material to wheelchair seat, 15 minute checks while out of bed, and motion sensor to door frame to alert staff when resident is entering room in place to prevent falls. Resident was checked on January 18, 2012 to ensure all interventions were in place and working correctly. RN managers were educated on 12-27-2011 on fall prevention and issues of interventions not provided to prevent falls. Managers are	

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F 323	Continued From page 37 Findings include: R35 experienced four falls in the facility from 10/12/11 through 12/2/11. R35's first fall was dated 10/12/11. She was found in her room on the floor by her bed. The Post Fall Huddle, dated 10/13/11 noted the TABs alarm (a personal body alarm) was in place although not sounding. Although the Post Fall Huddle report noted an "equipment malfunction" may have contributed to the fall, there was no indication in the Post Fall Huddle report or in the nursing notes dated 10/12/11 that the TABs alarm was inspected or adjusted, other than the string was measured. R35's fall dated 11/10/11 occurred in her bathroom, unwitnessed. The Post Fall Huddle dated 11/14/11 determined that R35 was attempting a self transfer to the toilet and the TABs alarm was sounding to alert staff. Review of the incident report dated 11/25/11 established R35 experienced an unwitnessed fall in her room. The incident report stated that the resident's TABs alarm was sounding, however, it did not note if the doorway motion sensor was in place or alarming, or why R35 was in her room alone. An incident report dated 12/2/11 noted that R35 experienced another unwitnessed fall in her room. The report noted that the TABs alarm was not sounding, and the doorway motion sensor was not mentioned. R35's Safety Risk Data Collection tool dated 10/1/11 identified that R35 needed a TAB alarm on and a motion sensor at her bed. R35's care plan, dated 10/4/11, directed staff to not leave the resident in her room alone. The care plan was updated on 11/16/11 to include a motion sensor placed at the room doorway to alert staff of her entering her room. R35's	F 323	monitoring fall interventions and educating staff as needed on an ongoing basis. DON will conduct all staff inservice on Policy for Incident &Accident Reporting on January 25, 2012. Staff not being able to attend will be given make-up packets or educated at mini inservices held during regular shift hours. Nursing designees will keep log of residents falls and interventions implemented for each fall. Residents care plan and care sheets will be audited to ensure that these match to ensure alarms are on residents and working correctly. These will be audited to include 12 residents weekly for 1 month; then to include 6 residents weekly for 1 month if compliance is noted and then as needed on an ongoing basis. The DON will summarize the findings of the audits, present them to the unit managers and to the QA committee for further recommendations and changes. Date completed: February 13, 2012	

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F 323	Continued From page 38 Minimum Data Set (MDS), dated 10/1/11, noted that R35 needed extensive assistance from two staff for transferring between surfaces. The unit manager (RN-B) stated on 12/21/11 at 7:15 a.m. that R35 was not to be left alone in her room, and the doorway motion sensor was to be in place to alert staff when she entered her room by herself. She said that she was not sure if the motion sensor was in place near the door at the time of the falls. She said that it should have been in place so staff would know R35 was in her room alone, but nowhere in the incident reports did it note that it was. She acknowledged that if the doorway motion sensor was in place, it would have alerted staff to R35's whereabouts, and possibly prevented the falls which occurred while she was alone in her room.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to make timely	F 325	F325 Facility failed to make timely modifications of resident (R31) diet and to accurately monitor food/fluid intake patterns. Resident R31's diet was changed and eating techniques implemented on December 12, 2012 per Speech Therapy recommendation. Telephone order was obtained from MD. Policy & Procedure regarding Meals Preparing and Serving was amended to include implementation of diet order changes from Speech Therapy immediately and MD order or telephone order is to be obtained. RN managers were educated on 12-27-2011 regarding issues with timely diet modification and inaccurate monitoring of food/fluid intake	

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F 325	Continued From page 39 modifications of 1 of 1 resident's (R31) diet and to accurately monitor food/fluid intake patterns. Findings include: Resident 31 (R31) had diagnoses that included dementia with behavior disturbance, esophageal stenosis, mood and depressive disorders and chronic pain. The most recent quarterly minimum data set (MDS) dated 10/10/11 identified R31 with severe cognitive impairment, presence of some mood indicators and behaviors and eating with supervision and staff set up. The MDS did not identify a swallowing disorder or a mechanically altered diet. The current care plan dated 10/12/11 identified potential for nutritional imbalance related to uncooperative behaviors and mood; however, no problems or interventions were listed that related to swallowing problems or mechanical alteration of the diet. No significant weight loss had been recorded since admission and R31 was on the house nutritional supplement three times daily. Review of documents noted problems with swallowing and possible aspiration on 9/6/11 with thick white frothy sputum and coughing. A speech therapy referral with recommendations and physician order dated 9/21/22 identified, [Diet change to mechanical soft with thin liquids, continue speech therapy 5X/week for 2 weeks-dysphagia.]	F 325	patterns and have been reviewing these and addressing issues and educating staff as issues are noted. Policy & Procedure was presented at an all staff inservice on January 25, 2012 regarding diet order changes, processing of these orders, and documentation of food/fluids consumed. Staff not able to attend will be given make-up packets or educated at mini inservices held during regular shift hours. The DON or nursing designee will conduct audits of residents charts to ensure systematic compliance regarding appropriate diet implementation to include 12 residents weekly for 1 month; then to include 6 residents weekly for 1 month if compliance is noted and then on an ongoing basis as needed to ensure systematic compliance. The DON or nursing designee will also audit food/fluid intake sheets to include 12 residents weekly for 1 month; then to include 6 residents weekly for 1 month if compliance is noted and then on an ongoing basis as needed. The DON will summarize the findings of the audits, present them to the unit managers and to the QA committee for further recommendations and changes. Date completed: February 13, 2012	

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F 325	Continued From page 40 The care conference summary dated 10/27/11 noted, [Diet reviewed, resident has been coughing with meals..will talk to physician about new esophageal video.] The registered nurse practitioner (RNP) visit progress note dated 11/21/11 read, [Staff had some concerns resident was coughing at meals, chance of aspiration.] Dietary orders were changed on 11/21/11 to nectar thick liquids and pureed food. A subsequent video swallow evaluation was ordered and completed on 12/19/11. The recommendations from the speech language pathologist (SLP) was for mechanical soft diet, ground meat and thin liquids. In addition to the texture recommendations, the SLP recommended other assistive techniques for positioning and eating to improve swallowing function. R31 returned from the swallow evaluation with the recommendation report the afternoon of 12/19/11, the first day of the survey. Evening meal observations of R31 beginning at 5:30 p.m. on 12/21/11 revealed continued serving of pureed food (bratwurst and vegetables) and nectar thick liquids. R31 consumed little if any food and liquids by the end of the meal and stated, "I would eat soup if they had it, depends on the kind." R31 received no encouragement after initial set up and nursing assistant-H (NA-H) stated he was not aware of any dietary texture change. Dietary aide-A reported R31 was supposed to be on nectar thick liquids and pureed food and if there was any change, nursing would have let them know that day.	F 325		

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F 325	Continued From page 41 The breakfast meal of 12/20/11 at 8:30 a.m. had thick liquids and soft cereal served that with little consumed by R31. The noon meal of 12/20/11 at 12:00 p.m. also served R31 pureed food and thick liquids and R31 did not eat any. The breakfast meal of 12/21/11 at 8:45 a.m. was noted to have thick liquids and scrambled eggs; R31 ate part of the eggs but little of the liquids were consumed. Dietary aide-C (DA-C) reported R31 was still to have pureed food and thick liquids. During the breakfast meal at 7:45 a.m. on 12/21/11 a nursing assistant was observed to verbally report to the unit nurse manager (RN-B), "[R31] doesn't want her thickened water, she's going to dump it out on the floor." RN-B went over to R31 and said, "You know you've had a problem drinking water lately," encouraged R31 to drink it and not dump it on the floor. R31 reported during interview at 9:45 a.m. on 12/21/11 she did not like the thick liquids or pureed food, "That's why I'm not eating it." Review of the food consumption record of the meals observed from 12/19/11 to 12/21/11 was largely incomplete. No record of the food/fluid consumed during the noon and evening meal of 12/19/11 and the noon meal of 12/20/11 was entered on the form and was blank. The breakfast of 12/20/11 noted 25% of the food consumed. The dietary manager also verified during interview	F 325		

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F 325	Continued From page 42 at 10:15 a.m. on 12/21/11, she was aware R31 did not like thick liquids but they were waiting for the physician to change the orders before serving the texture recommended by the SLP at the swallow study of 12/19/11. The dietary manager thought the physician would be there that day. The nurse manager RN-B also verified at 10:40 a.m. R31, "hates thick liquids," and she could have attempted to obtain a telephone order from the physician to change the dietary texture the day the recommendations were made. RN-B stated the eating techniques recommended by the SLP also could have been communicated to staff and started without obtaining a physician's order. The consultant SLP-B, who had accompanied R31 for the swallow study of 12/19/11 also verified at 11:20 a.m. on 12/22/11 R31's orders could have been changed with a telephone order from the physician on the day of the study and the positioning and eating technique recommendations could have been started without obtaining an order. The SLP-B also reported that a speech language pathologist's scope of practice qualified them to make an actual diagnosis of oropharyngeal function and swallowing disorders based on the studies performed but courtesy dictated contact and involvement of the physician to change the orders and this could have been by phone and was preferable to having the resident not eat or drink much for three additional days. A telephone order was obtained from the physician on 12/22/11 to change R31's diet back to thin liquids and mechanically soft foods.	F 325		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

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F 371	Continued From page 43 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 observation, interview, and document review the facility failed to ensure food was distributed and served under sanitary conditions for 25 of 25 residents on the Rosewood Unit. Findings include: The dietary aide was observed to dish up and serve food without washing hands following contact with a contaminated surface. On 12/19/11 at 5:15 p.m. dietary aide-B was observed to wear gloves while dishing up food. He was using utensils to dish up the primary course and used his gloved hand to pick up ready to eat foods, the bread products and cookies. Dietary aide-B was observed to walk over to the phone and place a call with his gloved hands. He then returned to the serving area to continue serving food to the residents. Dietary aide-B did not remove his gloves, wash his hands, and replace the gloves prior to returning to the food serving area. He continued to have glove to food contact with the bread products and cookies.	F 371	F371 Facility failed to ensure food was distributed and served under sanitary conditions for 25 of 25 residents on the rosewood unit. On December 22, 2011 a dietary inservice took place regarding the tag given on hand washing and glove use. A power point was presented (hand washing 101) along with the policy on hand washing and glove and tong use. The staff member who failed to follow procedure was educated individually and at the dietary inservice. Staff that were not present received copies of all materials. Compliance with training will be audited 3 times weekly for the first three months by CDM, supervisor, or other designee's assigned. If improvement is shown audits will be reduced to three times a month and on an ongoing basis as needed. Date complete: February 13, 2012	

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F 371	Continued From page 44 When interviewed on 12/19/11 at 5:40 p.m. dietary aide-B indicated it was "definitely my fault I was focused on getting what we needed I should have washed my hands and changed gloves." Review of the undated facility policy for hand washing provided by the dietary manager as current indicated employees should wash their hands frequently "to prevent infections and food-borne illness in residents and staff." During interview at 10:13 a.m. on 12/22/11 the dieting manager (DM) confirmed staff were educated to change their gloves and wash their hands after contamination which included using the phone and proceeding to touch ready to eat foods.	F 371		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.	F 425	F425 Facility did not ensure each resident received medications as ordered by the prescriber. Resident R30's nurse practitioner of the attending physician was notified of medication error and order was processed per nurse practitioner orders. RN managers were educated regarding processing of orders and issues noted during survey on 12-27-2011 and have educated nursing staff when needed as issues arise. DON or nursing designee will conduct an inservice to nursing staff on Policy and Procedure of physician orders/admission on January 25, 2012. Staff not able to attend will be given make-up packets or educated at mini inservices held during regular shift hours. DON or nursing designee will conduct chart audits on physician order completeness to	

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	245438	A. BUILDING _____ B. WING _____	12/22/2011

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 45 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility did not ensure each resident received medications as ordered by the prescriber for 1 of 10 residents (R30) reviewed for unnecessary medications. Findings include: R30 diagnoses included schizoaffective disorder, bipolar disorder, gross hematuria and frequent urinary tract infections. The admission minimum data set (MDS) dated 10/21/11 revealed R30 was cognitively intact but had frequent pain which disrupted sleep patterns. Review of R30's physician orders dated 12/7/11, indicated discontinuation of a previous order for Vicodin 5/500, every four hours, as needed for bladder pain. The hand written order was initialed by licensed practical nurse (LPN)-H, with indication that she had transcribed the order to the medication administration record (MAR). Review of R30's pharmacy review dated 12/7/11 noted that "numerous" medications had been discontinued on 12/7/11, "dictation pending." Review of R30's MAR dated 12/11 lacked indication that Vicodin 5/500, every four hours, as needed for bladder pain, was discontinued. R30 was administered one dose of Vicodin 5/500 on	F 425	ensure systematic compliance to include 12 residents weekly for 1 month; then to include 6 residents weekly for 1 month if compliance is noted; then on an ongoing basis as needed. The DON will summarize finding on the audits, present them to the unit managers and to the QA committee for further recommendations and changes. Date complete: February 13, 2012	

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F 425	Continued From page 46	F 425		

12/19/11 and on 12/20/11 a second dose was given.

During interview at 2:50 p.m. on 12/20/11, LPN-C verified R30 was still receiving Vicodin 5/500, as needed for bladder pain. LPN-C was not aware that there had been an order to discontinue this medication. Upon review of the order, LPN-C verified that LPN-H ' s initials under the hand-written order were indicative of the order having been transcribed to the MAR.

During interview at 3:15 p.m. on 12/20/11, director of nursing (DON) reported that the facility charge nurses were typically responsible for transcribing physician orders to the MAR. DON indicated that once an order was received from the physician, a stamp was placed below the order, where employees initialed to indicate they completed the appropriate steps for implementation of the new order. DON reported that the facility ' s process was to have a second nurse double-check the order and transcription, indicating completion of that process by drawing a line under the order and signing it in red pen. Upon review of R30's physician order for 12/7/11, DON verified there was no indication that the order and transcription were double-checked.

The facility's Physician Orders Policy, revised 1/13/11, indicated it was the facility's policy to implement orders in a complete, accurate and consistent manner. The facility's system for processing physician's orders when an order was discontinued included yellowing out the discontinued order, writing "DC" next to the order, indicating the date, time and nurse initial. The policy revealed that when orders were complete,

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F 425	Continued From page 47 the nurses were to initial each completed, stamped section. The policy added that the order would be checked by another nurse and a red line, placed under the order with the nurse's signature would indicate the process was complete.	F 425		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 431	F431 West & Rosewood medication carts failed to reduce the risk of cross contamination of medications due to open/damaged tops of creams contaminating other residents medication tubes. West unit and Rosewood unit medication carts were cleaned January 20, 2012. Ointments without caps or with damaged tops were replaced. Ointments with cream on outside of tubes or in med cart were cleaned. Ointments for residents were separated from other residents meds/ointments. All ointments are in separate zip-locked baggies on med cart. All three medication carts in facility were checked and adjusted so ointments are individually baggied and tops are on medications and separated from other residents medications. RN managers on 12-27-2011 were educated on current issues of survey regarding med carts and are educating nurses on importance of reducing risk of cross contamination. Medication Administration and Storage Policy was updated. DON will present Policy	

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F 431	Continued From page 48 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to reduce the risk of cross contamination of medications in 2 of 3 medication carts in the facility. Findings include: During the medication storage review, two of the three medication carts were found to have two open tubes of resident medications in small compartments with other resident's medications. The medication cart for the West Unit of the facility was observed to contain a tube of Nystatin cream (a prescription antifungal medication) without a cap and cream was noted on the side of the tube as well as on other medication tubes for two other residents. Review of the Rosewood Unit's medication cart established that a tube of Aspercreme (over the counter topical analgesic) had a damaged top which did not close securely. The damaged tube was in a compartment with medication which belonged to seven other residents.	F 431	and Procedure for Medication Administration and Storage on January 25, 2012 to staff. Staff not able to attend will be given make-up packets or educated at mini inservices held during regular shift hours. All medication carts in facility will be audited by DON or nurse designee two times a week for a month and then once a week for a month and then as needed on a continual basis to prevent this problem from reoccurring in the future. The DON will summarize findings of the audits, present them to the unit managers and present to the QA committee for further recommendations and changes. Date complete February 13, 2012	
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	F 465	F465 Facility failed to maintain a safe and comfortable environment for residents, staff and visitors. Resident room doors that were found to be scarred, splintered or scratched included:	

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F 465	Continued From page 49 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain a safe and comfortable environment for residents, staff and visitors. This had the potential to affect all 64 residents in the facility. Findings include: During the environmental tour with the facility's maintenance director on 12/22/11, at approximately 9:30 a.m., resident room doors and door trim were found to be marred, scraped and splintered. Damaged doors in the facility included, but not limited to, resident rooms; 102, 103, 106, 107, 108, 112, 116, 118, 152, 154, 157, 160, 164, 167, 171, 175, 179, 181, 183, 185 and 191. In addition to the resident rooms, the secure doors to the Rosewood unit, the Rosewood shower room door and the Rosewood storage room door and trim, near resident room 110, were splintered and scratched. The maintenance director verified that the doors and trim in the facility needed a protective covering and/or refinishing to once again attain a homelike comfortable environment for the residents of the facility.	F 465	102, 103, 106, 107, 108, 112, 116, 118, 152, 154, 157, 160, 164, 167, 171, 175, 179, 181, 183, 185, 191, secure doors to Rosewood unit, Rosewood shower room door, and Rosewood storage room door and trim. The doors that needed to be replaced have been ordered. The door that needed to be replaced has been ordered and is being custom-made and will take 8-9 weeks to receive. In the meantime, while waiting for doors to be custom-made and delivered, the doors have been sanded and restained and finished. Protective covering has been ordered where needed. Upon completion of repairs. a safe, homelike comfortable environment for our residents will be provided.. The maintenance director will do audits of doors monthly to make sure doors remain clear of scratches and splinters. Completion date: February 3, 2012	

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	245438	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/21/2011

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K 000	INITIAL COMMENTS Surveyor: 27200 FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Talahi Care Center was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Talahi Center is a 2-story building with a partial basement. The building was constructed at 4 different times. The original building was constructed in 1964 and was determined to be of Type II(000) construction. In 1984, an addition was added to the north which was determined to be of Type II(000)construction. Both of these buildings are 1 story building with partial basements. In 1998 and addition was added to the northwest that was determined to be Type II(000) construction and is 2 stories with no basement. In 2004 two additions were added to to the north that were determined to be Type II(000) construction and are both 2 stories with no basements. The plans for these 2 additions were approved on 02-03-03. Because the original building and the additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is protected by a complete fire sprinkler system. The facility has a complete fire alarm system with smoke detection in the	K 000		

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

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

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K 000	Continued From page 1 corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a licensed capacity of 77 beds and had a census of 65 at the time of the survey.	K 000		