

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered January 7, 2021

Administrator
Talahi Nursing And Rehab Center
1717 University Drive Southeast
Saint Cloud, MN 56304

RE: CCN: 245438

Cycle Start Date: November 18, 2020

Dear Administrator:

On December 11, 2020, we informed you of imposed enforcement remedies.

On December 31, 2020, the Minnesota Department(s) of Health completed a revisit and it has been determined that your facility continues to not to be in substantial compliance. The most serious remaining deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

The deficiency(ies) not corrected is/are as follows:

In addition, at the time of this survey/revisit, we identified the following deficiency(ies):

As a result of the revisit findings:

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 10, 2021, will remain in effect.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444).

You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective January 10, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 10, 2021.

Talahi Nursing And Rehab Center January 7, 2021 Page 2

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

As we notified you in our letter of December 11, 2020, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 10, 2021.

### **ELECTRONIC PLAN OF CORRECTION (ePOC)**

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

#### DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), and emergency preparedness deficiencies (those preceded

Talahi Nursing And Rehab Center January 7, 2021 Page 3

by an "E" tag), i.e., the plan of correction should be directed to:

Susie Haben, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us

Office (220) 222 7250 Maleila (CEA) 220

Office: (320) 223-7356 Mobile: (651) 230-2334

#### PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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 ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

#### VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 18, 2021 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

Talahi Nursing And Rehab Center January 7, 2021 Page 4 formal notification of that determination.

#### **APPEAL RIGHTS**

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

### Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

### INFORMAL DISPUTE RESOLUTION/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

Nursing Home Informal Dispute Process Minnesota Department of Health Health Regulation Division P.O. Box 64900 Talahi Nursing And Rehab Center January 7, 2021 Page 5

#### St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <a href="https://mdhprovidercontent.web.health.state.mn.us/ltc\_idr.cfm">https://mdhprovidercontent.web.health.state.mn.us/ltc\_idr.cfm</a>

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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04 8.html

Diagon note that the failure to complete the informal dispute recolution process will not delay t

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

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist

Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit

Towards Stapson

Health Regulation Division

Telephone: 651-201-4118 Fax: 651-215-9697

Email: doug.larson@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted December 11, 2020

Administrator Talahi Nursing And Rehab Center 1717 University Drive Southeast Saint Cloud, MN 56304

RE: CCN: 245438

Cycle Start Date: November 18, 2020

#### Dear Administrator:

On November 18, 2020, survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

#### REMOVAL OF IMMEDIATE JEOPARDY

On November 18, 2020, the situation of immediate jeopardy to potential health and safety cited at F600 was removed. However, continued non-compliance remains at the lower scope and severity of G.

#### **REMEDIES**

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 10, 2021.
- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective January 10, 2021 (42 CFR 488.417 (a)), (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 10, 2021, (42 CFR 488.417 (a)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

### SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Talahi Nursing And Rehab Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective November 18, 2020. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

### **ELECTRONIC PLAN OF CORRECTION (ePOC)**

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the
  deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

#### **DEPARTMENT CONTACT**

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

Susie Haben, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us

Office: (320) 223-7356 Mobile: (651) 230-2334

### PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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 ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

#### **VERIFICATION OF SUBSTANTIAL COMPLIANCE**

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 18, 2021 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

### APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

#### Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

#### APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

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

### INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <a href="https://mdhprovidercontent.web.health.state.mn.us/ltc\_idr.cfm">https://mdhprovidercontent.web.health.state.mn.us/ltc\_idr.cfm</a>

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: <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04-8.html">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04-8.html</a>

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

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist

Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit

Towers Stapson

Health Regulation Division

Telephone: 651-201-4118 Fax: 651-215-9697

Email: doug.larson@state.mn.us

cc: Licensing and Certification File



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#### DIRECTED PLAN OF CORRECTION

A Directed Plan of Correction (DPOC) is imposed in accordance with 42 CFR § 488.424. Your facility must include the following in their POC for the deficient practice cited at F880:

### PERSONAL PROTECTIVE EQUIPMENT (PPE)

- 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.

### POLICIES/PROCEDURES/SYSTEM CHANGES:

• The facility's Quality Assurance and Performance Improvement Committee must conduct a root cause analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence.

The Infection Preventionist and Director of Nursing, shall complete the following:

- Review policies and procedures for donning/doffing PPE during COVID-19 with current guidelines to include crisis standard of care, contingency standard of care and standard care.
- Develop and implement a policy and procedure for source control masks.
- Review policies regarding standard and transmission based precautions and revise as needed.

#### TRAINING/EDUCATION:

As a part of corrective action plan, the facility must provide training for the Infection Preventionist, the Director of Nursing, all staff providing direct care to residents, and all staff entering resident's rooms, whether it be for residents' dietary needs or cleaning and maintenance services. The training must cover standard infection control practices, including but not limited to, transmission-based precautions, appropriate PPE use, and donning and doffing of PPE.

- The training may be provided by the Director of Nursing, Infection Preventionist, or Medical Director with an attestation statement of completion.
  - The training must include competency testing of staff and this must be documented.
- Residents and their representatives should receive education on the facility's Infection Prevention Control Program as it related to them and to the degree possible/consistent with resident's capacity.
- Online infection prevention training courses may be utilized. The CDC and MDH websites have several infection control training modules and materials.

#### CDC RESOURCES:

Infection Control Guidance: <a href="https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html">https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html</a> CDC: Isolation Precautions Guideline:

https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html

CDC: Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare

Settings (2007): <a href="https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html">https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html</a>

CDC: Personal Protective Equipment: <a href="https://www.cdc.gov/niosh/ppe/">https://www.cdc.gov/niosh/ppe/</a>

Healthcare Infection Prevention and Control FAQs for COVID-19:

https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html?CDC AA refVal=https%3A%2F%2Fwww.cd c.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-faq.html

#### MDH RESOURCES:

Personal Protective Equipment (PPE) for Infection Control:

https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/ppe/index.html

MDH Contingency Standards of Care for COVID-19: Personal Protective Equipment for Congregate Care

Settings (PDF): https://www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf

Interim Guidance on Facemasks as a Source Control Measure (PDF):

https://www.health.state.mn.us/diseases/coronavirus/hcp/maskssource.pdf

Interim Guidance on Alternative Facemasks (PDF):

https://www.health.state.mn.us/diseases/coronavirus/hcp/masksalt.pdf

Aerosol-Generating Procedures and Patients with Suspected or Confirmed COVID-19 (PDF):

https://www.health.state.mn.us/diseases/coronavirus/hcp/aerosol.pdf

**Droplet Precautions:** 

https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html Airborne Precautions:

https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html

#### MONITORING/AUDITING:

- The Director of Nursing, the Infection Preventionist, and other facility leadership will conduct audits of donning/doffing PPE with Transmission Based Precautions i.e. Droplet precautions.
- The Director of Nursing, Infection Preventionist, and other facility leadership will conduct routine audits on all shifts four times a week for one week, then twice weekly for one week once compliance is met. Audits should continue until 100% compliance is met on source control masking for staff, visitors and residents.
- The Director of Nursing, Infection Preventionist, and other facility leadership will conduct real time audits on all aerosolized generating procedures to ensure PPE is in us.
- The Director of Nursing, Infection Preventionist, or designee will review the results of audits and monitoring with the Quality Assurance Program Improvement (QAPI) program.

#### **EQUIPMENT/ENVIRONMENT**

- 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.

### POLICIES/PROCEDURES/SYSTEM CHANGES:

- The facility's Quality Assurance and Performance Improvement Committee must conduct a root cause analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence.
- The director of housekeeping, director of maintenance, and director of nursing must review
  policies and procedures regarding disinfecting multiuse/shared equipment/items and/or
  environmental disinfection to ensure they meet the CDC guidance for disinfection in health
  care facilities and follow disinfectant product manufacturer directions for use including contact
  time.

#### TRAINING/EDUCATION:

• The Director of Housekeeping/Maintenance, and/or Director of Nursing, or Infection Preventionist must train all staff responsible for resident care equipment and environment on the facility policies/practices for proper disinfection, including following manufacturer direction for use. Each staff person must demonstrate competency at the conclusion of the training.

Training and competency testing must be documented. The Minnesota Department of Health (MDH), Center for Disease Control (CDC), and Environmental Protection Agency have education materials that may be used for training.

- CDC: Infection Control Guidelines and Guidance Library. https://www.cdc.gov/infectioncontrol/guidelines/index.html/eic in HCF 03.pdf
- MDH COVID-19 Toolkit. https://www.health.state.mn.us/diseases/coronavirus/hcp/ltctoolkit.pdf
- EPA: List N: Disinfectants for Use Against SARS-CoV-2 (COVID-19) https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2-covid-19

#### CDC RESOURCES:

Infection Control Guidance: <a href="https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html">https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html</a> CDC: Isolation Precautions Guideline:

https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html

CDC: Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007): https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html

CDC: Personal Protective Equipment: <a href="https://www.cdc.gov/niosh/ppe/">https://www.cdc.gov/niosh/ppe/</a>

Healthcare Infection Prevention and Control FAQs for COVID-19:

https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html?CDC\_AA\_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-faq.html

#### MDH RESOURCES:

Personal Protective Equipment (PPE) for Infection Control:

https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/ppe/index.html
MDH Contingency Standards of Care for COVID-19: Personal Protective Equipment for Congregate Care
Settings (PDF): https://www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf
Interim Guidance on Facemasks as a Source Control Measure (PDF):

 $\underline{https://www.health.state.mn.us/diseases/coronavirus/hcp/maskssource.pdf}$ 

Interim Guidance on Alternative Facemasks (PDF):

https://www.health.state.mn.us/diseases/coronavirus/hcp/masksalt.pdf

Aerosol-Generating Procedures and Patients with Suspected or Confirmed COVID-19 (PDF):

https://www.health.state.mn.us/diseases/coronavirus/hcp/aerosol.pdf

Droplet Precautions:

https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html Airborne Precautions:

https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html

#### MONITORING/AUDITING:

• The Director of Nursing, the Infection Preventionist, and/or other facility leadership will conduct audits for proper cleaning and disinfection of resident use equipment/environmental cleaning, on all shifts every day for one week, then may decrease frequency as determined by compliance.

#### HAND HYGIENE

- 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.

#### POLICIES/PROCEDURES/SYSTEM CHANGES:

• The facility's Quality Assurance and Performance Improvement Committee must conduct a root cause analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence.

The Infection Preventionist and Director of Nursing, shall complete the following:

• Review hand hygiene policies and procedures to ensure they meet CDC guidance, and revise as needed.

#### TRAINING/EDUCATION:

- As a part of corrective action plan, the facility must provide training for the Infection Preventionist, the
  Director of Nursing, all staff providing direct care to residents, and all staff entering resident's rooms,
  whether it be for residents' dietary needs or cleaning and maintenance services. The training must cover
  standard infection control practices, including but not limited to, transmission-based precautions and
  adequately caring for and disinfecting shared medical equipment. Findings of the RCA should also be
  incorporated into staff training.
- The Infection Preventionist, Director of Nursing and Clinical Education Coordinator must implement competency assessments for staff on proper hand hygiene and develop a system to ensure all staff have received the training and are competency
- Online infection prevention training courses may be utilized. The CDC and MDH websites have several infection control training modules and materials.

https://www.health.state.mn.us/people/handhygiene/ (MDH)
Hand Hygiene (MDH) https://www.health.state.mn.us/people/handhygiene/index.html
Hand Hygiene for Health Professionals (MDH)

https://www.health.state.mn.us/people/handhygiene/index.html

Cleaning Hands with Hand Sanitizer (MDH)

https://www.health.state.mn.us/people/handhygiene/clean/index.html

CDC: Guideline for Hand Hygiene in Health-Care Settings (CDC)

https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5116a1.htm

WHO Guidelines on Hand Hygiene in Health Care (WHO)

https://apps.who.int/iris/bitstream/handle/10665/44102/9789241597906\_eng.pdf;jsessionid=A770

590E49844880F6F3E1D8F22F0841?sequence=1

Hand Hygiene in Outpatient and Home-based Care and Long-term Care Facilities (WHO)

https://www.who.int/gpsc/5may/hh\_guide.pdf

#### CDC RESOURCES:

Infection Control Guidance: <a href="https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html">https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html</a>

CDC: Isolation Precautions Guideline: <a href="https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html">https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html</a> CDC: Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings

(2007): https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html

CDC: Personal Protective Equipment: https://www.cdc.gov/niosh/ppe/

Healthcare Infection Prevention and Control FAQs for COVID-19:

https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html?CDC AA refVal=https%3A%2F%2Fwww.cdc.gov%2F

<u>coronavirus%2F2019-ncov%2Fhcp%2Finfection-contro</u>l-faq.html

#### MDH RESOURCES:

Personal Protective Equipment (PPE) for Infection Control:

https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/ppe/index.html

MDH Contingency Standards of Care for COVID-19: Personal Protective Equipment for Congregate Care Settings

(PDF): https://www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf

Interim Guidance on Facemasks as a Source Control Measure (PDF):

https://www.health.state.mn.us/diseases/coronavirus/hcp/maskssource.pdf

Interim Guidance on Alternative Facemasks (PDF):

https://www.health.state.mn.us/diseases/coronavirus/hcp/masksalt.pdf

Aerosol-Generating Procedures and Patients with Suspected or Confirmed COVID-19 (PDF):

https://www.health.state.mn.us/diseases/coronavirus/hcp/aerosol.pdf

Droplet Precautions: <a href="https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html">https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html</a>
Airborne Precautions: <a href="https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html">https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html</a>

#### MONITORING/AUDITING:

• The Director of Nursing, the Infection Preventionist and other facility leadership will conduct audits on all shifts, every day for one week, then may decrease the frequency based upon compliance. Audits should continue until 100% compliance is met.

The Director of Nursing, Infection Preventionist or designee will review the results of audits and monitoring with the Quality Assurance Program Improvement (QAPI) program.

#### SOCIAL DISTANCING CONCERNS

• 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.

### POLICIES/PROCEDURES/SYSTEM CHANGES:

• The facility's Quality Assurance and Performance Improvement Committee must conduct a root cause analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence.

### The Infection Preventionist and Director of Nursing, shall complete the following:

- Develop and implement procedures and policies to provide for, and enforce social distancing among residents/staff.
- Develop and implement procedures and policies to provide for social distancing during dining and/or activities.
- Assess each individual resident's ability to understand or willingness to comply with social distancing and care plan interventions to promote compliance.
- Develop and implement procedures to educate and remind residents to practice social distancing.
- Follow current CDC and MDH guidance on communal dining. (i.e. clothe masks/6 feet apart)
- Follow current CDC and MDH guidance on communal activities. (i.e. clothe masks/6 feet apart)

#### TRAINING/EDUCATION:

As part of a corrective action plan, the facility must provide training for Infection Preventionist, the Director of Nursing, all staff in the facility whether it be dietary, housekeeping staff, or activity staff. The training must cover the importance of social distancing of residents/staff/discontinuation of communal dining and activities. Online infection prevention training courses may be utilized. The Center for Disease Control (CDC) has specific COVID-19 training videos which cover social distancing and discontinuation of communal dining/activities.

 $\frac{https://www.cdc.gov/coronavirus/2019-ncov/communication/videos.html?Sort=Date%3A%3Adesc\&Search=nursing%20home$ 

Additional information may be used from the MDH COVID-19 Toolkit\_: <a href="https://www.health.state.mn.us/diseases/coronavirus/hcp/ltctoolkit.pdf">(https://www.health.state.mn.us/diseases/coronavirus/hcp/ltctoolkit.pdf</a>)

- Include documentation of the training completed with a timeline for completion.
- Include documentation of the training completed with a timeline for completion

#### CDC RESOURCES:

Infection Control Guidance: <a href="https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html">https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html</a> CDC: Isolation Precautions Guideline:

https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html

CDC: Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare

Settings (2007): https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html

CDC: Personal Protective Equipment: https://www.cdc.gov/niosh/ppe/

Healthcare Infection Prevention and Control FAQs for COVID-19:

 $\underline{https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html?CDC\_AA\_refVal=https\%3A\%2F\%2Fwww.}$ 

cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-faq.html

#### MDH RESOURCES:

Personal Protective Equipment (PPE) for Infection Control:

https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/ppe/index.html

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Care Settings (PDF): https://www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf

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https://www.health.state.mn.us/diseases/coronavirus/hcp/maskssource.pdf

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https://www.health.state.mn.us/diseases/coronavirus/hcp/masksalt.pdf

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**Droplet Precautions:** 

https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html

Airborne Precautions:

https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html

#### MONITORING/AUDITING:

• The Director of Nursing, the Infection Preventionist and other facility leadership will conduct rounds throughout the facility on each shift to ensure social distancing is being maintained by all staff and residents during various times of day and during various activities. The rounds will be conducted every day for four weeks, or until 100% compliance is obtained. Then the audits/monitoring may be decreased in frequency.

The Director of Nursing, Infection Preventionist, or designee will review the results of audits and monitoring with the Quality Assurance Program Improvement (QAPI) program.

In accordance with 42 CFR § 488.402(f), the DPOC remedy is effective 15 calendar days from the date of the enforcement letter. The DPOC may be completed before or after that date. A revisit will not be approved prior to receipt of documentation confirming the DPOC was completed. To successfully complete the DPOC, the facility must provide all of the following documentation identified in the chart below.

Documentation must be uploaded as attachments through ePOC to ensure you have completed this remedy.

Imposition of this DPOC does not replace the requirement that the facility must submit a complete POC for all cited deficiencies (including F880) within 10 days after receipt of the Form CMS 2567.

| Item | Checklist: Documents Required for Successful Completion of the Directed Plan   |
|------|--|
| 1    | Documentation of the RCA and intervention or corrective action plan based on the results with signatures of the QAPI Committee members.                        |
| 2    | Documentation that the interventions or corrective action plan that resulted from the RCA was fully implemented  |
| 3    | Content of the training provided to staff, including a syllabus, outline, or agenda, as well as any other materials used or provided to staff for the training |
| 4    | Names and positions of all staff that attended and took the trainings  |
| 5    | Staff training sign-in sheets  |
| 6    | Summary of staff training post-test results, to include facility actions in response to any failed post-tests  |
| 7    | Documentation of efforts to monitor and track progress of the interventions or corrective action plan  |

In order to speed up our review, identify all submitted documents with the number in the "Item" column.

PRINTED: 01/11/2021 FORM APPROVED OMB NO. 0938-0391

| 1                        | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                    |     | E CONSTRUCTION  | ` ' | E SURVEY<br>IPLETED        |
|--------------------------|--|--|--------------------|-----|---|-----|----------------------------|
|                          |  |  |                    |     |   | R-C |                            |
|                          |  | 245438   | B. WING            |     |   | 12/ | 31/2020                    |
| NAME OF I                | PROVIDER OR SUPPLIER   |  |                    | ST  | REET ADDRESS, CITY, STATE, ZIP CODE   |     |                            |
| TALAHI                   | NURSING AND REHA   | AB CENTER  |                    |     | 17 UNIVERSITY DRIVE SOUTHEAST<br>AINT CLOUD, MN 56304   |     |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPI<br>DEFICIENCY) | BE  | (X5)<br>COMPLETION<br>DATE |
| {E 000}                  | Initial Comments   |  | {E 0               | 00} |   |     |                            |
| {F 000}                  | Centers for Medica<br>Appendix Z Emerg<br>requirement(s) dur<br>Infection Control su<br>INITIAL COMMEN   |  | {F 0               | 00} |   |     |                            |
|                          | (PCR) was comple<br>deficiencies issued<br>complaint survey e<br>Nursing and Rehal<br>compliance with 42   | nsite post certification revisit ted to follow up on Federal I related to an abbreviated xited on 11/18/20. Talahi Center was found not in 2 CFR Part 483, Subpart B, the Long Term Care Facilities. |                    |     |   |     |                            |
|                          | corrected: H54380 non-compliance wi  | plaint(s) were found to be<br>195C; however, unrelated<br>th identified and cited as part<br>gation at F609 and F610.  |                    |     |   |     |                            |
| F 609<br>SS=D            | as your allegation of Department's access enrolled in ePOC, year the bottom of the form. Your electron be used as verificate receipt of an accept of your facility may substantial compliabeen attained in account of the protection.  Reporting of Allege |  | F€                 | 609 |   |     | 1/10/21                    |
|                          |  | onse to allegations of abuse,<br>n, or mistreatment, the facility  |                    |     |   |     |                            |
| LABORATOR                | Y DIRECTOR'S OR PROVI  | DER/SUPPLIER REPRESENTATIVE'S SIG  | NATURE             |     | 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.

**Electronically Signed** 

01/07/2021

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | 1` '  |                    | TIPLE CONSTRUCTION   |  | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--|---|--------------------|--|--|-------------------------------|--|
|   |  |   |                    |  | R  | R-C                           |  |
|   |  | 245438  | B. WING            |  | 12/                                      | 31/2020                       |  |
|   | PROVIDER OR SUPPLIER  NURSING AND REHA   | B CENTER  |                    | STREET ADDRESS, CITY, STATE, ZIP COD<br>1717 UNIVERSITY DRIVE SOUTHEAST<br>SAINT CLOUD, MN 56304   |  |                               |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |  | OULD BE                                  | (X5)<br>COMPLETION<br>DATE    |  |
| F 609   | involving abuse, nemistreatment, inclusiource and misappare reported immediate hours after the allest that cause the allest serious bodily injurithe events that cause and do not reported that cause and do not reported the administrator of officials (including the administrator and serious bours and including the accordance with Starvey Agency, with incident, and if the appropriate correct this REQUIREMED by:  Based on interview facility failed to enspotential sexual abadministrator and serious and s | are that all alleged violations aglect, exploitation or ding injuries of unknown ropriation of resident property, diately, but not later than 2 gation is made, if the events gation involve abuse or result in y, or not later than 24 hours if se the allegation do not involve esult in serious bodily injury, to f the facility and to other the facility and to other to the State Survey Agency eservices where state law exion in long-term care ance with State law through the administrator or his or her entative and to other officials in ate law, including to the State hin 5 working days of the alleged violation is verified ive action must be taken.  Now the state agency (SA) in a timely esidents (R2) whose | F                  | Allegation made by R2 has reported to OHFC on 12/31/20 plan reviewed/updated to inclu of making this specific allegati     Other known allegations on have been reported timely     Resident protection plan plan. | 20. Care<br>de history<br>on.<br>f abuse |                               |  |
|   |  | mum Data Set (MDS), dated   |                    | reviewed  • Nursing home staff to be eimportance of reporting and in   | educated on<br>vestigating               |                               |  |
|   | 11/22/20, identified   | R2 had moderate cognitive   |                    | all allegations of abuse to Adm  | inistrator                               |                               |  |

|                          |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` ′                 | PLE CONSTRUCTION  S  | (X3) DATE SURVEY<br>COMPLETED   |                            |
|--------------------------|---|---|---------------------|--|---|----------------------------|
|                          |   | 245438  | B. WING             |  |   | -C<br><b>31/2020</b>       |
|                          | PROVIDER OR SUPPLIER  |   |                     | STREET ADDRESS, CITY, STATE, ZIP CO<br>1717 UNIVERSITY DRIVE SOUTHEAS<br>SAINT CLOUD, MN 56304   | DDE   | 5 17 E G E G               |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORI<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY)   | SHOULD BE   | (X5)<br>COMPLETION<br>DATE |
| F 609                    | impairment and debehaviors or halludidentified R2 consimedication and recomplete his activity.  On 12/31/20, at 1: R2 expressed he have for "almost nine mand the felt the staff treadded, "But I got recomplete his activity of the staff treadded, "But I got recomplete his activity of the staff treadded, "But I got recomplete his activity of the staff treadded, "But I got recovided their first surveyor, voicing the ware away from the "vocational school incident to "two so and they were "look he did not feel safe result of being raped R2's progress note were reviewed. The pisodes from 8/1/2 or outlined R2 as repotentially sexually 8/28/20 to 12/31/2 recorded:  On 8/29/20, R2 was talking about friend and someone name and how it hurt reacconfront him and confront him and continued to discutthe note lacked at the staff of the staff | emonstrated no delusional cinations. Further, the MDS umed daily antipsychotic quired extensive assistance to ties of daily living (ADLs).  17 p.m. R2 was interviewed. The properties and admitted he was all health concerns. R2 reported atted him well; however, he then aped two times here." R2 raped by two male persons and and last names to the his rape happened while they be nursing home and at a "R2 voiced he reported the cial workers in this building" of the nursing home as a series of the singuistic stated at the nursing home as a | F 609               | and State Agency in timely many regardless of perceived accurallegation.  • Audits for staff knowledge and investigating abuse to be a week for four weeks, month months, and on-going as new on reviewed audit results.  • Audit results to be review monthly QAPI to evaluate the effectiveness of audit continute.  • NHA/Designee is response ensuring compliance.  • Corrective Date of Company 1/10/2021 | e of reporting e completed 3 hly for two eded based wed at e lation sible for |                            |

|                          |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                 | PLE CONSTRUCTION  G  | COV     | (X3) DATE SURVEY COMPLETED |  |
|--------------------------|--|--|---------------------|--|---------|----------------------------|--|
|                          |  | 245438   | B. WING             |  |         | R-C<br>/ <b>31/2020</b>    |  |
|                          | PROVIDER OR SUPPLIER   |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1717 UNIVERSITY DRIVE SOUTHEAST<br>SAINT CLOUD, MN 56304      | •       | 01/2020                    |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE | (X5)<br>COMPLETION<br>DATE |  |
| F 609                    | On 8/31/20, R2 was throughout the shift police station! I was provided reassurar conversation which temporarily effective. On 9/1/20, the sock which outlined she recent statements feeling safe in the concerns with his concluded, "Resider recently and has not months. He has an his psychiatrist on On 9/2/20, R2 was most of the night a because " some loudly and voiced "down and raped his voiced he knew the had reported it is note continued, "Here yet."  On 9/3/20, R2 was provided orders for on 9/9/20, R2 voice about being raped stating we need to On 9/10/20, R2's pregarding R2's received. | is recorded as yelling out it including, "Bring me to the s raped 3 times!" The staff nce and one-to-one in was listed as " mildly and ve."  ial worker completed a note had spoken with R2 on his of being raped. R2 reported nursing home and did not have caregivers. The note ent has not left the building of had any visitors for several in appointment scheduled with 9/3/20."  In recorded as being awake and putting his legs out of bed one was coming." R2 shouted with in and then laughed "R2 ese guys, named them and that to the police department. The e [R2] asked if the police were a seen by his psychiatrist which is medication adjustment.  The note outlined, "Resident is the police were in the police we | F 609               |  |         |                            |  |

| CLIVILI         | 13 I ON MEDICANE   | - & MEDICAID SERVICES   |  |     |  | IVID IVO.                     | 0930-0391  |
|-----------------|--|---|--|-----|--|-------------------------------|------------|
|                 | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION A. BUILDING |     |  | (X3) DATE SURVEY<br>COMPLETED |            |
|                 |  |   |  |     |  | R                             | -C         |
|                 |  | 245438  | B. WING                                | ;   |  | 12/                           | 31/2020    |
| NAME OF F       | PROVIDER OR SUPPLIER   |   |  | S   | STREET ADDRESS, CITY, STATE, ZIP CODE      |                               |            |
| <b>TAL ALL!</b> | WIDOWG AND DELLA   | D OFNITED   |  | 1   | 717 UNIVERSITY DRIVE SOUTHEAST             |                               |            |
| IALAHII         | NURSING AND REHA   | AB CENTER   |  | 5   | SAINT CLOUD, MN 56304                      |                               |            |
| (X4) ID         | SUMMARY STA  | ATEMENT OF DEFICIENCIES   | ID                                     |     | PROVIDER'S PLAN OF CORRECTIO               | N                             | (X5)       |
| PREFIX          | (EACH DEFICIENCY   | Y MUST BE PRECEDED BY FULL  | PREF                                   | IX  | (EACH CORRECTIVE ACTION SHOULD             | BE                            | COMPLETION |
| TAG             | REGULATORY OR L  | SC IDENTIFYING INFORMATION)   | TAG                                    | i   | CROSS-REFERENCED TO THE APPROP DEFICIENCY) | RIATE                         | DATE       |
|                 |  |   | 1                                      | —   | 22.13.2.13.1                               |                               |            |
| F 609           | Continued Frame no   | 4   | _                                      | 000 |  |                               |            |
| 1 003           | Continued From pa  | _   | F                                      | 609 |  |                               |            |
|                 |  | with immediately following  |  |     |  |                               |            |
|                 |  | he was in the local hospital d in his lifetime. R2 voiced not       |  |     |  |                               |            |
|                 |  | nursing home and the nurses   |  |     |  |                               |            |
|                 |  | and the supernatural" and his                                       |  |     |  |                               |            |
|                 |  | cked him into a corner and  |  |     |  |                               |            |
|                 |  | re OK it was 8 months ago."   |  |     |  |                               |            |
|                 | R2 believed it was   | a ghost hurting people. R2's  |  |     |  |                               |            |
|                 |  | irt Note, dated 9/10/20,  |  |     |  |                               |            |
|                 |  | ion from R2's psychiatrist  |  |     |  |                               |            |
|                 |  | parently [R2] has been making                                       |  |     |  |                               |            |
|                 |  | had been raped by male staff  |  |     |  |                               |            |
|                 |  | ntly there are no male staff  |  |     |  |                               |            |
|                 |  | cility. I told [the nursing home or recollection of any time in the |  |     |  |                               |            |
|                 |  | d indicated any sexual abuse  |  |     |  |                               |            |
|                 |  | rred. He's never implied it,  |  |     |  |                               |            |
|                 |  | med it at any time in the many                                      |  |     |  |                               |            |
|                 |  | een him." The note outlined R2                                      |  |     |  |                               |            |
|                 |  | l, at times, and continued,   |  |     |  |                               |            |
|                 | ,  | laims of sexual abuse very  |  |     |  |                               |            |
|                 |  | t [R2] is complaining of I would                                    |  |     |  |                               |            |
|                 |  | s if not totally so that this                                       |  |     |  |                               |            |
|                 |  | nal thinking on his part, at least                                  |  |     |  |                               |            |
|                 |  | d of assault occurring toward                                       |  |     |  |                               |            |
|                 |  | s. Whether or not he had gone a child is something that he has      |  |     |  |                               |            |
|                 |  | the 25 plus years that I have                                       |  |     |  |                               |            |
|                 | known him."  | Title 20 plus years that I have                                     |  |     |  |                               |            |
|                 |  |   |  |     |  |                               |            |
|                 | There were no reco   | orded progress note(s) from   |  |     |  |                               |            |
|                 | 9/11/20 to 12/17/20  | ), which R2 alleged being   |  |     |  |                               |            |
|                 | sexually assaulted   | or raped.   |  |     |  |                               |            |
|                 | On 40/40/00 DO   |   |  |     |  |                               |            |
|                 |  | ad a telehealth visit with his                                      |  |     |  |                               |            |
|                 |  | ysician where he reported "   |  |     |  |                               |            |
|                 |  | aped twice by [F-A] and [F-D] e." The person completing the         |  |     |  |                               |            |
|                 |  | et safe at the nursing home,  |  |     |  |                               |            |

| AND DUAN OF CORRECTION TO THE TOTAL NUMBER. |  | A. BUILDING   |  |     |   | COMPLETED R-C |                            |
|---|--|---|--|-----|---|---------------|----------------------------|
|   |  | 245438  | B. WING  |     |   | 1             | 31/2020                    |
|   | PROVIDER OR SUPPLIER   | AB CENTER   | STREET ADDRESS, CITY, STATE, ZIP CO 1717 UNIVERSITY DRIVE SOUTHEAS SAINT CLOUD, MN 56304 |     |   | DDE           |                            |
| (X4) ID<br>PREFIX<br>TAG                    | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG   |     | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULE<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE          | (X5)<br>COMPLETION<br>DATE |
| F 609                                       | and reported the coworker (LSW)-A. A completed by LSW LSW-A visited with rape. R2 reported they were living too note continued, "[L not happen recentl facility for two year friends like he reported a history of making On 12/21/20, R2 as about " being rapurse reassured R with R2 regarding to be causing him to a to being raped.  On 12/22/20, R2's orders for R2's premedication. A subsidentified LSW-A a with R2 as he had being raped by F-A person(s) voiced the explained he believed the sherburne County "chasing the guys on R2 identified one on LSW-A voiced the visitors "for a long reviewed the woun causing pain; howe and voiced, "That's additional note, dail psychiatrist was up allegations of rape | age 5 concern to the facility' social a corresponding note, 1-A on 12/18/20, identified R2 about the allegation of the incident happened when gether "six months ago." The SW-A] confirmed that this did y and resident has been at s, and was not living with orted." R2 was listed as having a delusional statements.  Igain voiced to the nursing staff oed by '[F-C] and [F-A]." The 2 of his safety and discussed the wound on his bottom may attribute the pain in his bottom psychiatrist provided new scribed antipsychotic sequent note, dated 12/22/20, and the nurse manager met voiced more statements of and F-C. R2 reported these ney were "coming for him" and wed he was currently in the building and the nurse was down that raped him outside." If these persons as F-C and facility had not been accepting time," so he was safe and d on his bottom maybe ever, R2 then became offended a not true!" Further, an ited 12/22/20, identified R2's odated on the verbalized. The note identified the ded, "You have done | F 6  | 609 |   |               |                            |

|                          | AND BLAN OF CORRECTION ' IDENTIFICATION NUMBER: '   |  | IPLE CONSTRUCTION  NG | СОМ   | COMPLETED R-C |                            |
|--------------------------|---|--|-----------------------|---|---------------|----------------------------|
|                          |   | 245438   | B. WING_              |   |               | -C<br>31/2020              |
|                          | PROVIDER OR SUPPLIER  |  |                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1717 UNIVERSITY DRIVE SOUTHEAST<br>SAINT CLOUD, MN 56304           |               |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRODER (DEFICIENCY) | JLD BE        | (X5)<br>COMPLETION<br>DATE |
| F 609                    | everything you can delusional disorder delusions. this [sic medication at this medication was invoiced they would On 12/23/20, R2 v last night" and he dintercom. R2 denies building, but reitera On 12/28/20, R2 v raped stating he "s would not let him on R2 again voiced the hurt "really bad." R " awhile ago, like hearing the mens' named F-A and F-distressed by the old want is an apolog R2's care plan, data being at risk for "in system and, as a r F-B help to offer min such decision medication in such decision medications, revised on 9/1/20, of experiencing events which is an application in such decision medications. | to manage this, it is a rand these are not new needs to be managed with point." R2's antipsychotic creased; and the psychiatrist follow up in two weeks.  Diced to staff F-C "was here could hear him through the ed physically seeing F-C in the lated he could hear him.  Diced a concern about being saw them" last night and they contact the police department. It is men had raped him and it 2 voiced the incident happened be June or July." R2 reported voices "all the time" and C. R2 did not appear conversation and voiced, " all by from them."  Ted 11/29/20, identified R2 as appaired function" in his support esult, R2's friends (F)-A and redical advice and advise him aking. R2 was recorded as atropic medications for having a history of delusions cinations which cause agitation. Linued and outlined two both last initiated and/or which dictated R2 had a history ents which were " physically | F 60                  | 09  |               |                            |
|                          | The care plan conseparate sections, revised on 9/1/20, of experiencing evand emotionally hadescribed as, " happened recently  | tinued and outlined two<br>both last initiated and/or<br>which dictated R2 had a history   |                       |   |               |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTII<br>A. BUILDIN  | PLE CONSTRUCTION  G | (X3) DATE SURVEY COMPLETED   |         |                            |
|---|--|--|---------------------|--|---------|----------------------------|
|   |  | 245438   | B. WING             |  | l l     | R-C<br>:/ <b>31/2020</b>   |
|   | PROVIDER OR SUPPLIER   |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1717 UNIVERSITY DRIVE SOUTHEAST<br>SAINT CLOUD, MN 56304      |         | 10112020                   |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE | (X5)<br>COMPLETION<br>DATE |
| F 609   | delusions and hall caused R2 to belie room who he would Further, the care put being raped due to often believing it has everal intervention these problems in answer questions consulting with some services, and provided the care put R2 alleging episod when it was added However, R2's melacked evidence the potential sexual as administrator when administrator when administrator when the provided untitled lined in the provided untitled | ucinations which, at times, eve others were present in his ld voice are having sex. plan outlined R2, "Talks about to history of sexual violence, appened recently," and outlined ans to to help R2 cope with cluding allowing R2 time to and verbalize feelings, cial services or psychiatric riding opportunities for R2 and e in care. Further, a provided report, printed 12/31/20, lan lacked any information on les of being raped until 9/1/20, d. edical record was reviewed and the multiple allegations of estate agency (SA). Further, a sting, dated 3/11/20 to 12/5/20, facility's reported allegations of ect. R2's repeated allegations | F 60                |  |         |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTI<br>A. BUILDIN | PLE CONSTRUCTION  G  |                              | (X3) DATE SURVEY<br>COMPLETED |  |
|---|---|---|--------------------------|--|------------------------------|-------------------------------|--|
|   |   | 245438  | B. WING _                |  |                              | R-C<br>/ <b>31/2020</b>       |  |
|   | PROVIDER OR SUPPLIER  |   |                          | STREET ADDRESS, CITY, STATE, ZIP<br>1717 UNIVERSITY DRIVE SOUTHE<br>SAINT CLOUD, MN 56304  | CODE                         | 70172020                      |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)                  | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | N SHOULD BE<br>E APPROPRIATE | (X5)<br>COMPLETION<br>DATE    |  |
| F 609   | would also, at time "come through the "come through the "Come through the "A manager (RN)-A wexplained she had and described him reported people we allowing any visitor voiced she was aw of being raped by thad "brought it up" meetings. RN-A voallegations had alrainvestigated "when determine no actual occurring to R2. As allegations (starting reported or investig planned the allegations (starting reported or investig planned the allegations as "person of contact" "who came to visit" restrictions being pp.m. LSW-A and Rain December 2018 the hospital severatotal assistance wire was "not very good and hallucinations." | ugh intercoms and aloud. R2 s, voice these persons would  | F 60                     |  |                              |                               |  |
|   | in-depth" by thems<br>team. However, the<br>reported to the SA  | en "talked about pretty elves and the management e voiced allegations were not as they were under the |                          |  |                              |                               |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | ` '   | ` ′                 | TIPLE CONSTRUCTION NG   | (X3) DATE SURVEY<br>COMPLETED |    |
|---|---|---|---------------------|---|-------------------------------|----|
|   |   | 245438  | B. WING             |   | R-C                           |    |
|   | PROVIDER OR SUPPLIER  |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304         | 12/31/2020                    |    |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFILIENCY) | D BE COMPLÉTIC                | NC |
| F 609   | online call was place Department of Hear specialist with RN-Ar specialist reviewed submitted allegation submitted reporting any allegation(s) of RN-A, RN-B and LS reported as they be done and care plane the administrator joexplained she first the past couple were completing frequent survey's plan of corracknowledged the I supporting the allegor the SA and voice repeated allegation potential vulnerable history of accusation reportable" given history of accusation reportable given history of accusation potential vulnerable history of accusation reportable given history of accusation potential vulnerable history of accusation reportable given history of accusation reportable given history of accusation reportable follow to the prevention policy, of acility would follow to the prevention of any nursing home of such allegations them to the administ then report them to Further, the policy of report to the [SA] in hours after the allegations after the allegations after the allegations and the support to the policy of report to the [SA] in hours after the allegations | ehavioral. At this time, an eled to the Minnesota and LSW-A present. The the Federal database forms and verified there was no to the SA for R2 regarding sexual assault and/or rape. SW-A reiterated it was not lieved it had already been ned accordingly. At 3:00 p.m. ined the interview and earned of the allegations in eks as the facility started to behavior meetings for a prior rection. The administrator ack of documentation gation(s) being reported to hered, to her knowledge, the swere not filed or treated as a cadult (VA) issue given R2's ns as they felt it "was not | F 6                 | 09  |                               |    |
| {F 610}<br>SS=D   | Investigate/Prevent   | /Correct Alleged Violation  | {F 61               | 0}  | 1/10/21                       |    |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | L. IDENTIFICATION NUMBER.  |                    | (2) MULTIPLE CONSTRUCTION . BUILDING   |  | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--|--|--------------------|--|--|-------------------------------|--|
|   |  | 245438   | B. WING            |  |  | 31/2020                       |  |
|   | PROVIDER OR SUPPLIER   |  |                    | STREET ADDRESS, CITY, STATE, ZIP ( 1717 UNIVERSITY DRIVE SOUTHEA SAINT CLOUD, MN 56304   | CODE   |                               |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |  | N SHOULD BE  | (X5)<br>COMPLETION<br>DATE    |  |
| {F 610}   | neglect, exploitation must:  §483.12(c)(2) Haviolations are thorough the violations are thorough the violation in vestigation is in §483.12(c)(4) Reginvestigations to the violation of the v | onse to allegations of abuse, on, or mistreatment, the facility be evidence that all alleged oughly investigated.  Went further potential abuse, on, or mistreatment while the   | {F 6               | ,  |  |                               |  |
|   | This REQUIREME<br>by: Based on intervie<br>facility failed to en<br>potential sexual al<br>investigated to rule<br>protection plan(s)<br>residents (R2) ren<br>residing at the nur<br>Findings include:<br>R2's quarterly Min<br>11/22/20, identifie<br>impairment and do<br>behaviors or hallu-<br>identified R2 cons<br>medication and re  | etive action must be taken. ENT is not met as evidenced w and document review, the sure voiced allegations of ouse were thoroughly e out abuse and determine if were needed to ensure 1 of 4 nained free of abuse while sing home.  imum Data Set (MDS), dated d R2 had moderate cognitive emonstrated no delusional cinations. Further, the MDS umed daily antipsychotic quired extensive assistance to ities of daily living (ADLs). |                    | <ul> <li>Allegation made by R2 reported to State agency or has been investigated, and determined to not be substa Resident sexual vulnerabilit updated. Care plan reviewed include history of making spallegation.</li> <li>Other resident allegation have been investigated at the Resident protection pla reviewed</li> <li>Nursing home staff to be importance of reporting and all allegations of abuse to A and State Agency in timely regardless of perceived accallegation. All allegations of</li> </ul> | n 12/31/2020, has been antiated. ty assessment ed/updated to pecific ons of abuse his time n policy pe educated on d investigating administrator manner, curacy of the |                               |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING |     |  | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|--|--|--|-----|--|-------------------------------|----------------------------|
| 245438  |  | B. WING  |  |     | R-C<br><b>12/31/2020</b>   |                               |                            |
| NAME OF PROVIDER OR SUPPLIER                        |  |  |  | S   | TREET ADDRESS, CITY, STATE, ZIP CODE   |                               |                            |
| TALAHI  | NURSING AND REHA   | AB CENTER  |  |     | 717 UNIVERSITY DRIVE SOUTHEAST<br>AINT CLOUD, MN 56304   |                               |                            |
| (X4) ID<br>PREFIX<br>TAG                            | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   |  | ID<br>PREFI<br>TAG                     |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPI<br>DEFICIENCY)  | BE                            | (X5)<br>COMPLETION<br>DATE |
| {F 610}   | On 12/31/20, at 1: R2 expressed he h for "almost nine me to mental health co staff treated him w "But I got raped twe was raped by two n their first and last n this rape happened the nursing home a R2 voiced he report workers in this built into it." Further, R2 the nursing home a R2's progress note were reviewed. The On 12/12/19, R2 w paranoid thoughts [friend; F-A] 'is goin staff provided a on effective in re-assu On 6/28/20, R2 ha and voiced to them to kill him. The poli and the charge nun history of delusiona them R2 was safe.  On 7/6/20, R2 retu voiced, "A threat to and F-C as being i how to kill R2. The of resident's who us | and lived at the nursing home on this and admitted there due on the and at a recorded and at a recorded and the and th | {F 6-                                  | 10} | investigated thoroughly by NHA/designee(s), and plan of care updated to ensure resident safety.  • Audits for staff knowledge of reand investigating abuse to be compound to make the compound on the compound of the compound | bleted 3<br>two<br>ased       |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING |  |         | (X3) DATE SURVEY COMPLETED  R-C |  |
|---|---|---|--|--|---------|---------------------------------|--|
|   |   | 245438  | B. WING                                |  | l       | ≺-∪<br>/31/2020                 |  |
| NAME OF PROVIDER OR SUPPLIER  TALAHI NURSING AND REHAB CENTER |   |   |  | STREET ADDRESS, CITY, STATE, ZIP COE<br>1717 UNIVERSITY DRIVE SOUTHEAST<br>SAINT CLOUD, MN 56304       | )E      | 12/01/2020                      |  |
| (X4) ID<br>PREFIX<br>TAG                                      | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                    | PROVIDER'S PLAN OF CORRE<br>( (EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE API<br>DEFICIENCY) | OULD BE | (X5)<br>COMPLETION<br>DATE      |  |
| {F 610}   | Continued From pa   | age 12  | {F 6                                   | 0}   |         |                                 |  |
|   | 8/1/19 to 8/28/20, v  | orded progress note(s) from which described or outlined R2 raped or potentially sexually  | •                                      |  |         |                                 |  |
|   | talking about F-A a someone names [s how it hurt really ba him and do someth as-needed pain me to discuss the "rape | s recorded as frequently nd voiced, " [F-A] and sic] [redacted] raped him and adly and we need to confront hing about it." R2 was provided edication, however, continued to issue" afterwards. The note in on if the administrator had ne allegation. |  |  |         |                                 |  |
|   | throughout the shif<br>police station! I was<br>provided reassurar  | s recorded as yelling out<br>t including, "Bring me to the<br>s raped 3 times!" The staff<br>ace and one-to-one<br>was listed as " mildly and<br>e."  |  |  |         |                                 |  |
|   | which outlined she recent statements feeling safe in the reconcerns with his concluded, "Reside recently and has no | al worker completed a note had spoken with R2 on his of being raped. R2 reported nursing home and did not have earegivers. The note ent has not left the building of had any visitors for several appointment scheduled with 9/3[/20]."               |  |  |         |                                 |  |
|   | most of the night and because " some loudly and voiced " down and raped his voiced he knew the                      | recorded as being awake and putting his legs out of bed one was coming." R2 shouted three guys knocked him and then laughed" R2 ese guys, named them and that to the police department. The   |  |  |         |                                 |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  |                     |  | COMPLETED  R-C |                            |
|---|--|--|---------------------|--|----------------|----------------------------|
|   |  | 245438   | B. WING_            |  | 1              | 2/31/2020                  |
| NAME OF PROVIDER OR SUPPLIER  TALAHI NURSING AND REHAB CENTER                                       |  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1717 UNIVERSITY DRIVE SOUTHEAST<br>SAINT CLOUD, MN 56304      |                |                            |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE        | (X5)<br>COMPLETION<br>DATE |
| {F 610}   | note continued, "He here yet."  On 9/3/20, R2 was provided orders for corresponding  On 9/9/20, R2 voice about being raped. stating we need to  On 9/10/20, R2's peregarding R2's recewhich R2's psychia serious delusions a R2 was conversed where R2 believed and had been rape feeling safe at the ridid not " underst friends had " backlaughed and they a R2 believed it was  R2's corresponding identified the dictat which read, " Apstatements that he members. Apparer members at the facts staff] that I have no past where [R2] had that had ever occurs unggested it or clai years that I have see as being delusiona "While I take any controlled the controlled the dictated that the dever occurs was seen to clai years that I have see as being delusiona "While I take any controlled the dictated the dictated that I have see as being delusiona "While I take any controlled the dictated the dictated that I have see as being delusiona "While I take any controlled the dictated that I have see as being delusiona "While I take any controlled the dictated that I have see as being delusiona "While I take any controlled the dictated that I have see as being delusiona" | e [R2] asked if the police were seen by his psychiatrist which medication adjustment. A  ed per "State" to complain The note outlined, "Resident | {F 61               | 0}   |                |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION A. BUILDING |   |         | (X3) DATE SURVEY COMPLETED R-C |  |
|---|--|---|--|---|---------|--------------------------------|--|
|   |  | 245438  | B. WING                                |   |         | K-C<br>2/31/2020               |  |
| NAME OF PROVIDER OR SUPPLIER  TALAHI NURSING AND REHAB CENTER |  |   |  | STREET ADDRESS, CITY, STATE, ZIP COE<br>1717 UNIVERSITY DRIVE SOUTHEAST<br>SAINT CLOUD, MN 56304    | )E      |                                |  |
| (X4) ID<br>PREFIX<br>TAG                                      | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                    | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY) | OULD BE | (X5)<br>COMPLETION<br>DATE     |  |
| {F 610}   | represents delusion in terms of any kinhim in recent times through abuse as a never brought up it known him."  There were no recent 1/2 sexually assaulted On 12/18/20, R2 horimary medical point that he had been rethis week sometimente identified R2 and reported the coworker (LSW)-A. A completed by LSW-A visited with rape. R2 reported they were living togethey were | nal thinking on his part, at least d of assault occurring toward s. Whether or not he had gone a child is something that he has n the 25 plus years that I have orded progress note(s) from 0, which R2 alleged being | {F 61                                  | 0}  |         |                                |  |

|   |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′                 | TIPLE CONSTRUCTION  NG  | COM                          | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--|--|---------------------|---|------------------------------|-------------------------------|--|
|   |  | 245438   | B. WING             |   | R-C<br><b>12/31/2020</b>     |                               |  |
| NAME OF PROVIDER OR SUPPLIER  TALAHI NURSING AND REHAB CENTER |  |  |                     | STREET ADDRESS, CITY, STATE, ZIP<br>1717 UNIVERSITY DRIVE SOUTHE<br>SAINT CLOUD, MN 56304 | CODE                         |                               |  |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION) |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)       | N SHOULD BE<br>E APPROPRIATE | (X5)<br>COMPLETION<br>DATE    |  |
| {F 610}   | SUMMARY STATEMENT OF DEFICIENCIES  X (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)    |  | {F 6^               |   |                              |                               |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION A. BUILDING |     |   | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|--|---|--|-----|---|-------------------------------|----------------------------|
|   |  | 245438  | B. WING                                |     |   | l                             | -C<br><b>31/2020</b>       |
| NAME OF PROVIDER OR SUPPLIER  TALAHI NURSING AND REHAB CENTER |  |   |  | 1   | TREET ADDRESS, CITY, STATE, ZIP CODE 717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304                         | 12/                           | 5172020                    |
| (X4) ID<br>PREFIX<br>TAG                                      | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG                      |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY) | BE                            | (X5)<br>COMPLETION<br>DATE |
| {F 610}   | R2's care plan, date being at risk for "im system and, as a re F-B help to offer min such decision maconsuming psycholoschizophrenia and and auditory halluc. The care plan contiseparate sections, revised on 9/1/20, vof experiencing everand emotionally hadescribed as, " whappened recently, psychosocial well-bedeusions and hallucaused R2 to believ room who he would Further, the care plang raped due to often believing it has several intervention these problems inconsulting with soc services, and proving family to participate Care Plan History reverified the care plang R2 alleging episode when it was added.  However, R2's mediacked evidence the potential sexual assocomprehensively in | ed 11/29/20, identified R2 as a paired function" in his support esult, R2's friends (F)-A and edical advice and advise him aking. R2 was recorded as tropic medications for having a history of delusions inations which cause agitation. Indeed and outlined two both last initiated and/or which dictated R2 had a history ents which were " physically rmful" including sexual abuse which I will sometimes believe "R2 was listed as having being problem(s) due to his acinations which, at times, we others were present in his divoice are having sex. I an outlined R2, "Talks about history of sexual violence, appened recently," and outlined as to to help R2 cope with luding allowing R2 time to and verbalize feelings, ial services or psychiatric ding opportunities for R2 and a in care. Further, a provided eport, printed 12/31/20, an lacked any information on es of being raped until 9/1/20, dical record was reviewed and e multiple allegations of | {F 6                                   | 10} |   |                               |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | A. BUILDIN  | IPLE CONSTRUCTION IG | (X3) DATE SURVEY COMPLETED   |         |                            |
|--|---|---|----------------------|--|---------|----------------------------|
|  |   | 245438  | B. WING_             |  | l l     | R-C<br>:/ <b>31/2020</b>   |
|  | PROVIDER OR SUPPLIER  |   |                      | STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304            |         | 75172020                   |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE | (X5)<br>COMPLETION<br>DATE |
| {F 610}  | remained safe need R2 accusing some care plan as a fried decisions. Further, provided during the a state agency (SA completed and substituted | eded to be implemented despite cone whom was listed on his and who helps him make there was no evidence to onsite survey which outlined (A) 'Five-Day' report had been omitted demonstrating such open completed since 8/29/20, the an allegation of rape while | {F 610               | 0}   |         |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | ` ′   | TIPLE CONSTRUCTION ING |                                 | (X3) DATE SURVEY<br>COMPLETED  |                            |
|---|--|---|------------------------|---------------------------------|--------------------------------|----------------------------|
|   |  | 245438  | B. WING                |                                 |                                | R-C<br>/ <b>31/2020</b>    |
|   | PROVIDER OR SUPPLIEF   |   | 1                      | STREET ADDRESS, CITY, STATE, ZI | P CODE                         | 75172020                   |
| TALAHI  | NURSING AND REH  | AB CENTER   |                        | SAINT CLOUD, MN 56304           |                                |                            |
| (X4) ID<br>PREFIX<br>TAG  | X (EACH DEFICIENCY MUST BE PRECEDED BY FULL  |   | ID<br>PREFI<br>TAG     |                                 | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETION<br>DATE |
| {F 610}   | allegations had all investigated "wher determine no actu occurring to R2. A allegations (starting reported or investigations) allegations (starting reported or investigations) allegations of contact who came to visit restrictions being p.m. LSW-A and F. They explained R2 in December 2018 the hospital severatotal assistance with was "not very good and hallucinations the allegations in Stallegations had be in-depth" by thems team. However, the just care planned evidence they coure peated allegation investigated as and despite R2 alleging perpetrator (AP) with nursing home in the never investigated under the impressivation and explained she in the past couple completing freque survey' plan of cor | ready been reported and an they fist happened" to all abuse had or was still as a result, the second ag on 12/18/20) were not gated as they had already care ations as behavioral. However, need one of the named persons as potentially raping him was a "for him who was someone" R2 prior to the COVID placed in March 2020. At 2:22 RN-B joined the interviewed. It and had been "in and out" of all times since then. R2 required with his cares and his cognition d" given his history of delusions. They voiced R2 had voiced september 2020, and the sen "talked about pretty selves and the management are voiced allegations were then and there was no documented all provide demonstrating the nand there was no documented all provide demonstrating the nand there was no documented all provide demonstrating the nand there was no documented all provide demonstrating the nand there was no documented all provide demonstrating the nature of the allegation of sexual abuse, and the allegation of sexual abuse, and the allegation of the allegations. At inistrator joined the interview of the allegations weeks as the facility started and the heavier meetings for a prior rection. The administrator and the documentation and the documentation and the second and the second allegations weeks as the facility started and behavior meetings for a prior rection. The administrator and allegations weeks as the facility started and behavior meetings for a prior rection. The administrator allegations weeks as the facility started and behavior meetings for a prior rection. The administrator allegations weeks as the facility started and behavior meetings for a prior rection. The administrator | {F 6                   | 10}                             |                                |                            |

|                          | TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |  | ` ′     | TIPLE CONSTRUCTION NG  |             | (X3) DATE SURVEY<br>COMPLETED |  |  |
|--------------------------|--|--|---------|--|-------------|-------------------------------|--|--|
|                          |  | 245438   | B. WING |  |             | R-C<br>/ <b>31/2020</b>       |  |  |
|                          | PROVIDER OR SUPPLIER   | AB CENTER  |         | STREET ADDRESS, CITY, STATE, ZIP O<br>1717 UNIVERSITY DRIVE SOUTHEA<br>SAINT CLOUD, MN 56304 | CODE        | 70172020                      |  |  |
| (X4) ID<br>PREFIX<br>TAG | X (EACH DEFICIENCY MUST BE PRECEDED BY FULL  |  |         | PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)          | N SHOULD BE | (X5)<br>COMPLETION<br>DATE    |  |  |
| {F 610}                  | supporting a comp allegations and voi repeated allegation potential vulnerable history of accusation reportable" given hadministrator voice no actual abuse to someone with a hist delusional beliefs is given a risk staff w potential credible at A provided Vulneral Prevention policy, of acility would follow to the prevention of successing at the provided to the administration would complete to the inwith the resident provided with the resident provided and reviewed and reviewed and reviewed and reviewed and reviewed and reviewed allegations are completed and reviewed and reviewed and reviewed and reviewed and reviewed and reviewed allegations and reviewed a | rehensive investigation into the ced, to her knowledge, the as were not filed or treated as a set adult (VA) issue given R2's cons as they felt it "was not is history of such. The ed she felt there had likely been R2, however, acknowledged story of false accusations and as greatly susceptible to abuse could potentially not believe allegations.  Able Adult Abuse and Neglect dated 11/17/20, identified the are Federal guidelines dedicated fabuse and timely, thorough challegations. The policy tions were to be immediately ministrator, and then an all be completed which included two from all parties involved, ent' behavior and observations vestigation, and, following up hysician. The policy outlined, and written findings are iewed [and] A plan for termined with input from | {F 6^   | 0}   |             |                               |  |  |

PRINTED: 12/31/2020 FORM APPROVED OMB NO. 0938-0391

|                          | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:   |   | (X2) MUL<br>A. BUILD |     | LE CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |                            |
|--------------------------|---|---|----------------------|-----|--|-------------------------------|----------------------------|
|                          |   | 245438  | B. WING              |     |  | C                             |                            |
| NAME OF I                |   | 245436  | B. WING              |     | CTREET ADDRESS SITY STATE ZID SODE   | 11/                           | 18/2020                    |
|                          | PROVIDER OR SUPPLIER  NURSING AND REHA  | AB CENTER   |                      | 1   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1717 UNIVERSITY DRIVE SOUTHEAST<br>SAINT CLOUD, MN 56304              |                               |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG   |     | PROVIDER'S PLAN OF CORRECTIC<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | ) BE                          | (X5)<br>COMPLETION<br>DATE |
| E 000                    | Initial Comments  |   | ΕC                   | 000 |  |                               |                            |
|                          | Infection Control su<br>facility by the Minne<br>(MDH) to determine<br>Preparedness regu  | /18/20, a COVID-19 Focused urvey was conducted at your esota Department of Health e compliance with Emergency llations §483.73(b)(6). Talahi o was found in compliance with   |                      |     |  |                               |                            |
| F 000                    | signature is not req<br>page of the CMS-2<br>correction is require  | nrolled in ePOC, your juired at the bottom of the first 567 form. Although no plan of ed, it is required that the facility pt of the electronic documents.  | FC                   | 000 |  |                               |                            |
|                          | was completed at y<br>complaint investiga<br>Rehab was found r  | /18/20, an abbreviated survey<br>your facility to conduct<br>ition(s). Talahi Nursing and<br>not in compliance with 42 CFR<br>nents for Long Term Care  |                      |     |  |                               |                            |
|                          |   | plaints were found to be<br>138095C with a deficiency cited   |                      |     |  |                               |                            |
|                          | jeopardy (IJ) and si<br>IJ at F600 began o<br>resident's (R2) anti<br>abruptly stopped an<br>behaviors, including<br>behaviors, were no<br>developed to ensur<br>This ultimately con-<br>assaulting another | d in findings of immediate ubstandard quality of care. An n 10/19/20, when a behavioral psychotic medication was nd the resulted escalating g newly recorded sexual t assessed and interventions re safety of himself and others. tributed to R2 sexually dependent, non-verbal female resided at the nursing home. |                      |     |  |                               |                            |
| L ABORATOR'              | <br>Y DIRECTOR'S OR PROVI   | DER/SUPPLIER REPRESENTATIVE'S SIG   | NATURE               |     | TITLE  |                               | (X6) DATE                  |

Electronically Signed 12/18/2020

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

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.

|                          | OF DEFICIENCIES OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | l ' '               | TIPLE CONSTRUCTION NG   |         | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|---|---|---------------------|---|---------|-------------------------------|--|
|                          |   | 245438  | B. WING             |   |         | C<br>/ <b>18/2020</b>         |  |
|                          | PROVIDER OR SUPPLIER  |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODI<br>1717 UNIVERSITY DRIVE SOUTHEAST<br>SAINT CLOUD, MN 56304 |         |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPORTICIENCY)                | OULD BE | (X5)<br>COMPLETION<br>DATE    |  |
| F 580<br>SS=D            | director of nursing on 11/17/20, at 3:3 11/18/20; however an isolated scope of Further, an extend 11/18/20.  In addition, a COV survey was conducted with §483.80 Infect found to not be in crequirement.  The facility is enrol signature is not recognized and the verification of com acceptance. Upon electronic POC, armay be conducted compliance with the attained in accordance Notify of Changes CFR(s): 483.10(g)(14) No (i) A facility must in consult with the reconsistent with his representative(s) with the consistent with his representative (s) with the consistent in injury and physician intervent (B) A significant changes consistent changes consistent changes consistent changes consistent with his representative (s) with the results in injury and physician intervent (B) A significant changes consistent | cor of operations (RDO) and (DON) were notified of the IJ (DON) was removed on an incompliance remained at of actual harm (Level G). The factual harm (Level G) was conducted on a compliance to the determine compliance to Control. The facility was compliance with the compliance upon the Department's receipt of an acceptable of an acceptable of an acceptable of the compliance with your facility to validate that substantial the regulations has been ance with your verification. (Injury/Decline/Room, etc.) (14)(i)-(iv)(15) tification of Changes. In the resident when there is colving the resident which did has the potential for requiring control of the control of the control of the IJ (DON) was removed to the IJ (DON) was | F 0                 |   |         | 12/23/20                      |  |

| AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | l ` ′   | PLE CONSTRUCTION  IG | , COV   | COMPLETED      |                            |  |
|--|--|---|----------------------|---|----------------|----------------------------|--|
|  |  | 245438  | B. WING _            |   |                | /18/2020                   |  |
|  | PROVIDER OR SUPPLIER   | AB CENTER   |                      | STREET ADDRESS, CITY, STATE, ZIP COL<br>1717 UNIVERSITY DRIVE SOUTHEAST<br>SAINT CLOUD, MN 56304    | )E             | 10/2020                    |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRI<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY) | OULD BE        | (X5)<br>COMPLETION<br>DATE |  |
| F 580  | status in either lifeclinical complicatio (C) A need to alter a need to discontint treatment due to accommence a new (D) A decision to tresident from the fa §483.15(c)(1)(ii). (ii) When making not (14)(i) of this section all pertinent inform is available and prophysician. (iii) The facility must resident and the rewhen there is-(A) A change in resident and the rewhen there is-(A) A change in resident and the rewhen there is-(A) A change in resident and the rewhen there is-(A) A change in resident and the rewhen there is-(B) A change in resident and the rewhen there is-(C) (10) of this sectificity must be address phone number of the representative (s).  §483.10(g)(15)  Admission to a conthat is a composite §483.5) must disclett sphysical configurations that compart, and must speroom changes between the section of the sec | threatening conditions or ns); treatment significantly (that is, ue an existing form of dverse consequences, or to form of treatment); or ansfer or discharge the acility as specified in notification under paragraph (g) on, the facility must ensure that ation specified in §483.15(c)(2) ovided upon request to the st also promptly notify the sident representative, if any, or or roommate assignment 3.10(e)(6); or sident rights under Federal or tions as specified in paragraph on. St record and periodically is (mailing and email) and he resident | F 58                 |   |                |                            |  |
|  |  | v and document review. the  |                      | " R2 was discharged from t  | he facility on |                            |  |

|                          | OF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | l ` ′               | FIPLE CONSTRUCTION<br>NG   | , ,  | E SURVEY<br>PLETED         |
|--------------------------|--|--|---------------------|--|--|----------------------------|
|                          |  | 245438   | B. WING             |  |  | C<br><b>18/2020</b>        |
| NAME OF I                | PROVIDER OR SUPPLIER   |  | -                   | STREET ADDRESS, CITY, STATE, ZIP CO  |  | 10/2020                    |
|                          | NURSING AND REH  |  |                     | 1717 UNIVERSITY DRIVE SOUTHEAS   |  |                            |
| IALAIII                  | NONOINO AND INLII  | AD CENTER  |                     | SAINT CLOUD, MN 56304  |  |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORR ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)   | HOULD BE   | (X5)<br>COMPLETION<br>DATE |
| F 580                    | facility failed to en was notified in a tit treatments for 1 orefused required I subsequently miss prescribed antipsy.  Findings include:  A submitted state dated 11/6/20, ideallegation of sexual another female rehad been found in intercourse." The contacted and renewal subsequently Min 9/29/20, identified with moderate cog demonstrated no rejection of care (sexual Admission Record appointed guardia party.  On 11/13/20, at 12 G-A explained showhich had happer assaulting anothen nursing home, and mental state had I meds." G-A voice weeks afterwards refused the labora subsequently had antipsychotic media the lack of time | sure the appointed guardian mely manner of refused f 1 residents (R2) reviewed who aboratory monitoring and sed multiple doses of vichotic medication.  agency (SA) Incident Report, ntified a facility' reported all abuse involving R2 and sident. The report outlined R2 R1's room " having sexual report outlined the police were noved R2 from the facility.  imum Data Set (MDS), dated R2 had schizophrenia along gnitive impairment. Further, R2 hallucinations, delusions or ) behaviors. Further, R2's d, printed 11/18/20, identified an in (G)-A as his responsible  2:22 p.m. G-A was interviewed. As was aware of an incident are d involving R2 sexually resident while residing at the d expressed frustration as R2's been "stable until he went off his d she had not been notified until on 11/2/20, that R2 had attory monitoring and not been provided his ordered ication. G-A voiced frustration ly notification and expressed d a care conference with her | F 58                | 11/6/2020.  "Residents who refuse the psychotropic medications, tre labs have the potential to be a their appointed guardians or I makers are not notified of the Residents with psychotropic r will be monitored daily on bus for any refusals of psychotropic medications, treatments, or last of refusals occurs, the appoint guardians or legal decision montified of the refusal.  "Licensed nursing staff/Thon the importance of identifying and notifying appointed guardiand notifying appointed guardiand notifying appointed guardians of the residents with psychotropic medications, tre labs will be completed to valid appointed guardian or legal diappointed guardian or l | atments, or affected if egal decision erfusals. medications siness days bic abs. If patternated akers will be MA educated ng refusals dians or legal al. hs for nedications eratments or date that the ecision erefusal. eed at at ation |                            |

|                          | OF DEFICIENCIES OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MUL <sup>*</sup><br>A. BUILDI | TIPLE CONSTRUCTION ING   |                            | COMI  | E SURVEY<br>PLETED         |
|--------------------------|---|---|------------------------------------|--|----------------------------|-------|----------------------------|
|                          |   | 245438  | B. WING                            |  |                            |       | C<br>18/2020               |
|                          | PROVIDER OR SUPPLIER  | B CENTER  |                                    | STREET ADDRESS, CITY, STATE, Z<br>1717 UNIVERSITY DRIVE SOUTI<br>SAINT CLOUD, MN 56304 |                            | 1 11/ | 10/2020                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | NTEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                |  | TION SHOULD<br>THE APPROPI | BE    | (X5)<br>COMPLETION<br>DATE |
| F 580                    | towards the end of "not one word" of the was mentioned.  R2's progress note pharmacy came to medication and dra refused and threw I The note outlined, '[sic] medication sin The note identified updated.  R2's Medication Addated 10/2020 to 1 physician ordered resubsequent admini was listed for cloza medication) 500 minad a listed start dawas record as being until 10/20/20. From MAR identified nea medication were not of, "18," which was not available from progression of the conference had been along with RN-A and (LSW)-A. A section Review," was listed medications had be consents were on flacked any evidence monitoring, and the | October, and still even then he refusal and held medication of the refusal and held medication of the deliver R2's antipsychotic of the deliver R2's antipsychotic of the routine laboratory work. R2 his coffee at the employee. The registered nurse (RN)-A was of | F 5                                | 080  |                            |       |                            |

|                          | OF DEFICIENCIES OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MUL <sup>*</sup><br>A. BUILDI | TIPLE CONSTRUCTION                                       |                            | СОМ | E SURVEY<br>PLETED         |
|--------------------------|---|--|------------------------------------|--|----------------------------|-----|----------------------------|
|                          |   | 245438   | B. WING                            |  |                            |     | C<br>18/2020               |
|                          | PROVIDER OR SUPPLIER  | B CENTER   |                                    | STREET ADDRESS, CITY, STATE, 1717 UNIVERSITY DRIVE SOUTH |                            |     | 10/2020                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                |  | TION SHOULD<br>THE APPROPI | BE  | (X5)<br>COMPLETION<br>DATE |
| F 580                    | notes, were reviewed appointed guardiant of the refused labor antipsychotic medical on 11/13/20, at 1:00 interviewed. They was laboratory draw on was held as a result would not leave the laboratory draw being was safe to continuate reviewed R2's medical it lacked evidence for updated on those enurses should have 10/19/20. LSW-A wheld for R2 on 10/2 and medication hole "wasn't fully aware until R2 was hospitte expressed R2's guardated "right away. When interviewed director of nursing of the exact date was formally notified of and subsequent and held; however, recandly 10/26/20 at some to 10/26/20 at | d, including recorded progress ed and lacked evidence R2's had been immediately notified ratory monitoring and his cation being held as a result.  7 p.m. RN-A and LSW-A were erified R2 had refused his 10/19/20, and his clozapine to because the pharmacy emedication without the right of the record and acknowledged R2's guardian had been events, and voiced the cart ensured G-A was updated on erified a care conference was 3/20, and the laboratory draw downs not discussed as she of all of this [those events]" alized on 11/3/20. RN-A radian should have been defended to the refused laboratory draw the refused laborato | F 5                                | 80   |                            |     |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  |                     | (X3) DATE SURVEY<br>COMPLETED   |  |                            |
|--|---|--|---------------------|---|--|----------------------------|
|  |   | 245438   | B. WING_            |   |  | C<br><b>18/2020</b>        |
|  | PROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1717 UNIVERSITY DRIVE SOUTHEAST<br>SAINT CLOUD, MN 56304   |  |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY)  | LD BE  | (X5)<br>COMPLETION<br>DATE |
| F 580  | psychosocial and/or rephysician and/or reoutlined several exerquired 'prompt natter the resident's significantly," and,   | age 6 Iges in the resident's physical, or mental status to the esponsible party. The policy amples of issue(s) which otification' including, "A need to medical treatment "Refusal of treatment or yo (2) or more consecutive  | F 58                | 30  |  |                            |
|  | Exploitation The resident has the neglect, misappropriate and exploitation as includes but is not corporal punishment any physical or chetreat the resident's §483.12(a) The fact §483.12(a) (1) Not physical abuse, convoluntary seclusion This REQUIREMENT by:  Based on observative review, the facility (R2) with escalating recorded sexual becauses assessed and intermitigate risk to oth sexual assault of 1 whom was non-verification as | from Abuse, Neglect, and ne right to be free from abuse, oriation of resident property, defined in this subpart. This limited to freedom from nt, involuntary seclusion and emical restraint not required to medical symptoms. cility must- use verbal, mental, sexual, or rporal punishment, or | F 60                | " The facility completed vulner risk assessment on all residents, resident R1. Care plans were up and revised with identified areas vulnerability and/or risk. " Facility immediately identified residents with consistently misse refused psychotropic medication new/changing behaviors. No residents with consistents with consistents with consistents with residents with consistents with consistents with consistents with consistents with consistents with consistents with consistents. | including<br>dated<br>of<br>d any<br>d or<br>s and | 12/23/20                   |

| Name of Provider or Supplier   Street Address, City, State, Zip Code   1717 UNIVERSITY DRIVE SOUTHEAST   SAINT CLOUD, MN 56304   |        | E SURVEY<br>PLETED |                    | E CONSTRUCTION                       | ,           | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | T OF DEFICIENCIES<br>OF CORRECTION |           |
|--|--------|--------------------|--------------------|--------------------------------------|-------------|--|------------------------------------|-----------|
| RAME OF PROVIDER OR SUPPLIER   STREET ADDRESS, CITY, STATE, ZIP CODE   1717 UNIVERSITY DRIVE SOUTHEAST   SAINT CLOUD, MN 56304      (X4) ID   SUMMARY STATEMENT OF DEFICIENCIES   (EACH DEFICIENCY MUST BE PRECEDED BY FULL   REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX   TAG   CONTINUED   TAG   CROSS-REFERENCED TO THE APPROPRIATE   DEFICIENCY)      F 600   Continued From page 7   immediate jeopardy (IJ) situation for R1 when she was sexually assaulted by R2 while at the nursing home.   Behavior management policy was reviewed and updated to include:   |        | ?                  |                    |                                      | . DOILDII10 |  |                                    |           |
| TALAHI NURSING AND REHAB CENTER  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 600  Continued From page 7 immediate jeopardy (IJ) situation for R1 when she was sexually assaulted by R2 while at the nursing home.  The IJ began on 10/19/20, when R2 refused routine laboratory monitoring and his ordered antipsychotic medication was held without timely notification to the provider. R2 then demonstrated escalating behaviors, including newly recorded  STREET ADDRESS, CITY, STATE, ZIP CODE 1771 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 600  PREFIX TAG  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 600  Were identified.  "Behavior management policy was reviewed and updated to include: o Notification of primary physician/NP, Mental health professional, and resident representative will be updated as applicable if resident consistently refuses psychotropic medication.  "Vulnerable Adult Abuse and Neglect"   |        |                    |                    |                                      | . WING      | 245438   |                                    |           |
| TALAHI NURSING AND REHAB CENTER  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 600  Continued From page 7 immediate jeopardy (IJ) situation for R1 when she was sexually assaulted by R2 while at the nursing home.  The IJ began on 10/19/20, when R2 refused routine laboratory monitoring and his ordered antipsychotic medication was held without timely notification to the provider. R2 then demonstrated escalating behaviors, including newly recorded  SAINT CLOUD, MN 56304  PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH COR | $\neg$ | 10,2020            | •                  | TREET ADDRESS, CITY, STATE, ZIP CODE | S           |  | PROVIDER OR SUPPLIER               | NAME OF F |
| F 600  Continued From page 7 immediate jeopardy (IJ) situation for R1 when she was sexually assaulted by R2 while at the nursing home.  The IJ began on 10/19/20, when R2 refused routine laboratory monitoring and his ordered antipsychotic medication was held without timely notification to the provider. R2 then demonstrated escalating behaviors, including newly recorded  ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  PREFIX (EACH CORRECTIVE ACTION SHOULD BE (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 600  Were identified.  " Behavior management policy was reviewed and updated to include: o Notification of primary physician/NP, Mental health professional, and resident representative will be updated as applicable if resident consistently refuses psychotropic medication.  " Vulnerable Adult Abuse and Neglect  |        |                    |                    | 717 UNIVERSITY DRIVE SOUTHEAST       | 1           |  |                                    |           |
| F 600  Continued From page 7 immediate jeopardy (IJ) situation for R1 when she was sexually assaulted by R2 while at the nursing home.  The IJ began on 10/19/20, when R2 refused routine laboratory monitoring and his ordered antipsychotic medication was held without timely notification to the provider. R2 then demonstrated escalating behaviors, including newly recorded  F 600  Continued From page 7 immediate jeopardy (IJ) situation for R1 when she was sexually assaulted by R2 while at the nursing home.  F 600  F 600  Were identified.  Behavior management policy was reviewed and updated to include:  O Notification of primary physician/NP, Mental health professional, and resident representative will be updated as applicable if resident consistently refuses psychotropic medication.  " Vulnerable Adult Abuse and Neglect   |        |                    |                    | SAINT CLOUD, MN 56304                | 8           | B CENTER   | NURSING AND REHA                   | TALAHI    |
| F 600  Continued From page 7 immediate jeopardy (IJ) situation for R1 when she was sexually assaulted by R2 while at the nursing home.  The IJ began on 10/19/20, when R2 refused routine laboratory monitoring and his ordered antipsychotic medication was held without timely notification to the provider. R2 then demonstrated escalating behaviors, including newly recorded  F 600  Continued From page 7 immediate jeopardy (IJ) situation for R1 when she was sexually assaulted by R2 while at the nursing home.  F 600  F 600  Were identified.  Behavior management policy was reviewed and updated to include:  O Notification of primary physician/NP, Mental health professional, and resident representative will be updated as applicable if resident consistently refuses psychotropic medication.  " Vulnerable Adult Abuse and Neglect   |        | (X5)               | TION               | PROVIDER'S PLAN OF CORRECTION        | ID          | ATEMENT OF DEFICIENCIES                            | SUMMARY STA                        | (X4) ID   |
| immediate jeopardy (IJ) situation for R1 when she was sexually assaulted by R2 while at the nursing home.  The IJ began on 10/19/20, when R2 refused routine laboratory monitoring and his ordered antipsychotic medication was held without timely notification to the provider. R2 then demonstrated escalating behaviors, including newly recorded  were identified.  Behavior management policy was reviewed and updated to include:  Notification of primary physician/NP, Mental health professional, and resident representative will be updated as applicable if resident consistently refuses psychotropic medication.  Vulnerable Adult Abuse and Neglect  |        |                    | ULD BE<br>ROPRIATE | CROSS-REFERENCED TO THE APPROP       |             |  |                                    | PRÉFIX    |
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| was sexually assaulted by R2 while at the nursing home.  "Behavior management policy was reviewed and updated to include: o Notification of primary physician/NP, Mental health professional, and resident routine laboratory monitoring and his ordered antipsychotic medication was held without timely notification to the provider. R2 then demonstrated escalating behaviors, including newly recorded  "Behavior management policy was reviewed and updated to include: o Notification of primary physician/NP, Mental health professional, and resident representative will be updated as applicable if resident consistently refuses psychotropic medication.  "Vulnerable Adult Abuse and Neglect   |        |                    |                    | were identified                      |             | _  |                                    |           |
| home.  The IJ began on 10/19/20, when R2 refused routine laboratory monitoring and his ordered antipsychotic medication was held without timely notification to the provider. R2 then demonstrated escalating behaviors, including newly recorded  reviewed and updated to include:  o Notification of primary physician/NP, Mental health professional, and resident representative will be updated as applicable if resident consistently refuses psychotropic medication.  "Vulnerable Adult Abuse and Neglect  |        |                    | cv was             |                                      |             |  |                                    |           |
| o Notification of primary physician/NP, Mental health professional, and resident routine laboratory monitoring and his ordered antipsychotic medication was held without timely notification to the provider. R2 then demonstrated escalating behaviors, including newly recorded  o Notification of primary physician/NP, Mental health professional, and resident representative will be updated as applicable if resident consistently refuses psychotropic medication.  " Vulnerable Adult Abuse and Neglect   |        |                    |                    |                                      |             |  | -                                  |           |
| routine laboratory monitoring and his ordered antipsychotic medication was held without timely notification to the provider. R2 then demonstrated escalating behaviors, including newly recorded representative will be updated as applicable if resident consistently refuses psychotropic medication.  " Vulnerable Adult Abuse and Neglect  |        |                    |                    |                                      |             |  |                                    |           |
| antipsychotic medication was held without timely notification to the provider. R2 then demonstrated escalating behaviors, including newly recorded applicable if resident consistently refuses psychotropic medication.  " Vulnerable Adult Abuse and Neglect  |        |                    | resident           | Mental health professional, and re-  |             | )/19/20, when R2 refused                           | The IJ began on 10                 |           |
| notification to the provider. R2 then demonstrated escalating behaviors, including newly recorded psychotropic medication.  " Vulnerable Adult Abuse and Neglect   |        |                    |                    |                                      |             |  |                                    |           |
| escalating behaviors, including newly recorded "Vulnerable Adult Abuse and Neglect   |        |                    | y refuses          |                                      |             |  |                                    |           |
|  |        |                    |                    |                                      |             |  |                                    |           |
|  |        |                    |                    |                                      |             |  |                                    |           |
| knowledge of but failed to comprehensively to the vulnerability risk assessment.   |        |                    |                    |                                      |             |  |                                    |           |
| assess and develop interventions to help manage "Like Residents:   |        |                    | ent.               |                                      |             |  |                                    |           |
| and reduce the risk of injury or assault to others.  o House Audit was conducted to identify   |        |                    | to identify        |                                      |             |  |                                    |           |
| This contributed to R2 subsequently entering R1's any residents that have consistently   |        |                    |                    |                                      |             |  |                                    |           |
| room and sexually assaulting her; and although missed or refused psychotropic  |        |                    | ,                  |                                      |             |  |                                    |           |
| R2 was removed from the nursing home, the medications and are exhibiting   |        |                    |                    |                                      |             |  |                                    |           |
| facility had not reassessed R1's vulnerability to new/changing behaviors.  |        |                    |                    |                                      |             |  |                                    |           |
| potential abuse from others despite being o Residents who would have   |        |                    |                    | o Residents who would have           |             | m others despite being                             | potential abuse from               |           |
| sexually assaulted. The regional director of consistently missed or refused  |        |                    |                    |                                      |             |  |                                    |           |
| operations for Minnesota (RDO) and director of psychotropic medications and have   |        |                    |                    |                                      |             |  |                                    |           |
| nursing (DON) were notified of the IJ for R1 on new/changing behaviors would be  |        |                    |                    |                                      |             |  |                                    |           |
| 11/17/20, at 3:39 p.m. The IJ was removed on reviewed during morning meeting with  |        |                    |                    |                                      |             |  |                                    |           |
| 11/18/20, at 4:36 p.m. when the facility successfully implemented a removal plan;  IDT. Appropriate interventions and monitoring will be implemented based on  |        |                    |                    |                                      |             |  |                                    |           |
| successfully implemented a removal plan; monitoring will be implemented based on however, non-compliance remained at an isolated review.   |        |                    | based on           |                                      |             |  |                                    |           |
| scope with actual harm (Level G).  o Residents identified as high  |        |                    |                    |                                      |             | •  |                                    |           |
| vulnerability risk due to inability to   |        |                    |                    |                                      |             | diffi (Ecver C).                                   | Soope with actual i                |           |
| Findings include: physically and mentally defend oneself,  |        |                    |                    |                                      |             |  | Findings include:                  |           |
| will have care plans reviewed and  |        |                    |                    |                                      |             |  | 3                                  |           |
| A submitted state agency (SA) Incident Report, updated as applicable based on review.  |        |                    |                    |                                      |             | agency (SA) Incident Report,                       | A submitted state a                |           |
| dated 11/6/20, identified a facility's reported " System Correction:   |        |                    |                    |                                      |             |  |                                    |           |
| allegation of sexual abuse involving R1 and R2.  o Licensed staff were educated on the   |        |                    |                    |                                      |             |  |                                    |           |
| The report outlined R2 had been found in R1's appropriate procedure, including   |        |                    |                    |                                      |             |  |                                    |           |
| room " having sexual intercourse." The report notification of provider and resident  |        |                    | lent               |                                      |             | •  |                                    |           |
| outlined the police were contacted and removed representative, for consistently  |        |                    | U C -              |                                      |             |  |                                    |           |
| R2 from the facility, and R1 was transported to missed/refused psychotropic medication.  |        |                    |                    |                                      |             |  |                                    |           |
| the hospital for evaluation. Further, the report o Staff were provided education   |        |                    |                    |                                      |             |  |                                    |           |
| listed several witnesses to the allegation which included nursing assistant (NA)-A, NA-B, licensed of new/changing behaviors,  |        |                    | iagement           |                                      |             |  |                                    |           |

|                          | FOF DEFICIENCIES OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION A. BUILDING |     |  | (X3) DATE SURVEY<br>COMPLETED  |                            |
|--------------------------|--|---|--|-----|--|--|----------------------------|
|                          |  |   | A. DOILD                               |     |  |  |                            |
|                          |  | 245438  | B. WING                                |     |  |  | 18/2020                    |
|                          | PROVIDER OR SUPPLIER  NURSING AND REHA   | AB CENTER   |  | 17  | TREET ADDRESS, CITY, STATE, ZIP CODE<br>717 UNIVERSITY DRIVE SOUTHEAST<br>AINT CLOUD, MN 56304   |  |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG                     |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY)  | BE   | (X5)<br>COMPLETION<br>DATE |
| F 600                    | practical nurse (LP (RN)-B.  R2's quarterly MDS had schizophrenia person's ability to the and moderate cogredemonstrated not he rejection of care be supervision with an his room.  R2's most recent PReview and Evaluate R2 had schizophre psychotropic medicantipsychotic), cloranxiety), and cloza medication). The form the supervision which read was listed as happen assessment listed which read, "Do the resident to present others of interfer care?" This was an assessment identification der "Anticipate and meantipsychotic medical goal of being free related complication help R2 meet this goal of the resulting with the resulting with the supervision with the read complication help R2 meet this goal of being free related complication help R2 meet this goal of supervisions with the resulting supervisions and resulting superv | N)-A and registered nurse  6, dated 9/29/20, identified R2 (a disorder which affects a hink, feel, and behave clearly) nitive impairment. Further, R2 allucinations, delusions or chaviors, and required only imbulation in the corridor and esychotropic Medication ation, dated 9/22/20, identified in and received several cations including loxapine (an inazepam (used to reduce pine (another antipsychotic form identified a primary target id, "Hearing voices," and this ening every two weeks. The a radio-button style question is ese behaviors cause the a danger to themselves or the with the staff's ability to give inswered, "No." Further, the lied R2's behaviors and | F6                                     | 600 | implementation of new intervention increased monitoring and providing increased supervision as needed.  o Staff were re-educated on the pand procedure for Vulnerable Adult and Neglect Prevention. This include how to identify the signs and sympt possible abuse, especially amongs most vulnerable population. These and symptoms of possible abuse coinclude unknown bruising, unexplaic changes in resident condition, as wood and demeanor changes.  o Residents who have consistent missed or refused psychotropic medications and have new/changin behaviors will be reviewed during meeting with IDT.  "Monitoring:  o Administrator or Designee is responsible to complete QA (Qualit Assurance) tool on:  ¿ Residents identified to be at his based on the vulnerability risk assessment will be reviewed to ide interventions noted on the plan of cheing followed to ensure the reside safety. Audit will be completed were weeks, then monthly X 1 month.  o Residents who are receiving psychotropic medications will be refor missing/refused medications, chehaviors, and appropriate interver put in place in the care plan. Audit completed weekly X4 weeks, then monthly X 1 month. | coolicy Abuse des coms of t the signs an ned vell as tly gh risk ntify are are nt sekly X4 viewed hanging ntions |                            |

|                          |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |   |        | TE SURVEY<br>MPLETED<br>C  |
|--------------------------|--|---|---|---|--------|----------------------------|
|                          |  | 245438  | B. WING_                                |   | 11     | /18/2020                   |
|                          | PROVIDER OR SUPPLIER   |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304             |        |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | ULD BE | (X5)<br>COMPLETION<br>DATE |
| F 600                    | adverse side effect restlessness. Furth was considered a cognitive impairment interventions which behavioral issues of (IDT), evaluating for issues are identified close observation. In dictation on how Resure his or other R2's medical recort the following:  On 8/18/20, a progordered loxapine of the following:  On 8/18/20, a progordered loxapine of the psychiatric nursumonth.  On 10/1/20, a progordistic nursumonth.  In a progordistic nursumonth.  On 10/1/20, a progordistic nursumonth.  On 10/1/20, a progordistic nursumonth.  On 10/1/20, a progordistic nursumonth.  In a progordistic nursumonth. | ress note identified R2's vas reduced to 25 milligrams normal ECG (records the myour heart to check for heart were orders to follow-up with se practitioner (NP)-A in one | F 60                                    |   |        |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING   |                     |  | (X3) DATE SURVEY<br>COMPLETED |                            |
|--|--|---|---------------------|--|-------------------------------|----------------------------|
|  |  | 245438  | B. WING _           |  | 1                             | C<br>/ <b>18/2020</b>      |
|  | PROVIDER OR SUPPLIER   | B CENTER  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1717 UNIVERSITY DRIVE SOUTHEAST<br>SAINT CLOUD, MN 56304  |                               |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPREDEDICIENCY) | JLD BE                        | (X5)<br>COMPLETION<br>DATE |
| F 600  | demonstrated episoridentified a section interventions," whice [medical doctor] with observed, trauma in and monitoring, profexpression of feeling. There were no furth demonstrated by R 9/1/20 to 10/19/20.  On 10/19/20, a profession and drawarefused and threw Intervention and drawarefused and threw Intervention and the identified updated.  On 10/22/20 (three identified R2 had refused R2 it was re-approach R2 and so R2's clozapine profession R2's refusal to a 10/19/20, so no meadministration as a consuming (receivite everyday. The note "Please call and telling and refused in the second refused | odes of them. Further, the note labeled, "Care plan ch directed, "Notify MD th any mood changes are informed approach observing byide opportunities for | F 60                |  |                               |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | ` ′   | TPLE CONSTRUCTION  NG |   | COMPLETED |                            |
|---|--|---|-----------------------|---|-----------|----------------------------|
|   |  | 245438  | B. WING               |   | 1         | C<br><b>1/18/2020</b>      |
|   | PROVIDER OR SUPPLIER   |   |                       | STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304             |           | 1/10/2020                  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | ULD BE    | (X5)<br>COMPLETION<br>DATE |
| F 600   | recorded which ide on R2's refusal to a clozapine. The note Nystrom appointment possible]. Nystrom made for 11/12/20.  On 10/31/20, a proand sat by the 'We he needed anything began yelling at wr minutes a [NA] can looked at her and y [three times]." R2 w good portion" of the walking around, included and pushing the note lacked ar  | peentry progress note was ntified NP-B had been updated allow laboratory draw(s) for his econtinued, "[NP-B] wanted ent made ASAP [as soon as [psychiatry clinic] appointment "  gress note identified R2 came est Desk.' R2 was questioned if g by the staff, but then " iter to shut up. After a few ne down the hallway and he relled 'you fucking nigger' X3 was recorded as spending "a eday outside of his room cluding standing by the front outtons in attempt to open it. by evidence of interventions taff to calm or redirect R2 | F 60                  | 00  |           |                            |
|   | recorded as being, having hallucination at him and resident you' drew his arr going to punch nur is very abnormal be nurse sat down newhich was effective note identified the lard R2's lab(s) or caused resident to provided education draw, however, the be observed as resaggression or agitation at him and resident to provide the large resident to provide the large resident to provide the large resident to provide as resaggression or agitation. | ress note identified R2 was " very agitated, restless and ns during shift [nurse] waved t flicked nurse off, said 'fuck m back as if acting he was se." The note continued, "This ehavior for resident." The kt to R2 and talked with him e in calming him down. The aboratory had attempted to n the prior shift which is what become upset." R2 was on the importance of the lab e note outlined R2 continued to stless but without physical ution. The note continued, "[R2] stating 'I am hearing voices.'                              |                       |   |           |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |  |                         |       | (X3) DATE SURVEY<br>COMPLETED |  |
|--|--|--|---|--|-------------------------|-------|-------------------------------|--|
|  |  | 245438   | B. WING                                 |  |                         |       | C<br>18/2020                  |  |
|  | PROVIDER OR SUPPLIER   | B CENTER   |   | STREET ADDRESS, CITY, STATE, ZIF<br>1717 UNIVERSITY DRIVE SOUTH<br>SAINT CLOUD, MN 56304 |                         | 1 11/ | 10/2020                       |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                     |  | ON SHOULD<br>HE APPROPI | BE    | (X5)<br>COMPLETION<br>DATE    |  |
| F 600  | Nurse asked what is resident replied 'The hates me, and that identified the nurse proceeded to hug that and start crying. Go was contacted due restlessness and a twice a day as-need (3) day period " effectiveness."  R2's corresponding note, dated 10/31/2 had contacted the experiencing increas hallucinations pa [sic], though a scripare waiting for lab was patient continues to concerned for his a an order for clonazias-needed for three with, "Nursing staff PCP [primary care his agitation."  On 11/1/20, another which identified R2 around facility through the contact of the with identified R2 around facility through the contact of the which identified R2 around facility through the contact of the which identified R2 around facility through the contact of the which identified R2 around facility through the contact of the which identified R2 around facility through the contact of the contact | the voices were telling him and at no one likes me, everyone I should just die." The note provided comfort to R2 whom he nurse and become upset enevive (physician service) to R2's continued n order for clonazepam 0.5 mg ded was provided for a three until cozapine issue was s administered to R2 and the | F 6                                     |  |                         |       |                               |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MUL  | TIPLE CONSTRUCTION  NG |   | (X3) DATE SURVEY COMPLETED C |                            |
|--|---|---|------------------------|---|------------------------------|----------------------------|
|  |   | 245438  | B. WING                |   | 11                           | /18/2020                   |
|  | PROVIDER OR SUPPLIER  | B CENTER  |                        | STREET ADDRESS, CITY, STATE, ZIP CODI<br>1717 UNIVERSITY DRIVE SOUTHEAST<br>SAINT CLOUD, MN 56304     |                              |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG    | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SHI<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE                      | (X5)<br>COMPLETION<br>DATE |
| F 600  | threw desk supplied outlined education provided, however, more angry as staff provided time and and " appeared the refuse medications.  On 11/2/20, a progentered R2's room and was laying in the R2 proceeded to comprovided R2 his oral his right hand arout then took his hand. The note identified appropriate to grableft the room.  On 11/2/20, a substitution of the received from the end of the end | and encouragement was R2 " Becomes more and f re-approach." R2 was then space to express his feelings to calm down but continues to | F 6                    |   |                              |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING   |   | (X3) DATE SURVEY COMPLETED C   |     |                            |
|--|---|---|---|--|-----|----------------------------|
|  |   | 245438  | B. WING _   |  |     | /18/2020                   |
|  | PROVIDER OR SUPPLIER  |   |   | STREET ADDRESS, CITY, STATE, ZIP CO<br>1717 UNIVERSITY DRIVE SOUTHEAS<br>SAINT CLOUD, MN 56304 | ODE |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)   | ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) |  |     | (X5)<br>COMPLETION<br>DATE |
| F 600  | R2's corresponding dated 11/3/20, iden R2 had gone without wo weeks as he will draws. The note id [due to] not getting present, and typical labs drawn, so the seeking an order fraddendum was did "I [NP-B] don't marorders this Upor nurses stated that needed, now need threw a traffic constates that she has and aggressive as ED. Facility staff all behaviors at this tip provided to send R2's corresponding 11/3/20, identified chief complaint list R2 reported he was he resided at the nrecorded as throwinurses. R2 voiced been sent to the Esuicidal ideation. Revere completed and back to the nursing he is now willing medications." Furth progress note, data reported not taking him feel "stressed" | g Genevive Progress Note, ntified NP-B was contacted as put his ordered clozapine for was refusing to allow laboratory entified, "Behaviors increased med." R2's guardian was ally was able to get R2 to have nursing home staff were for the needed lab draw(s). An estated by NP-B which identified, hage this, his psych provider in calling site nurse back, site orders for labs no longer okay to send to ED [R2] at a distance and the is right now, wants sent into so aren't able to manage me." A telephone order was the ED.  If ED Provider Notes, dated R2 presented to the ED with a led as, "Aggressive behavior." Is homeless before then voicing ursing home, and also was ng a telephone at one of the he was unaware why he had D, but did endorse having the individual consultation did cleared him for discharge ghome. R2 was recorded as, " | F 60  |  |     |                            |

|                          | OF DEFICIENCIES OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | l ` ′              | TIPLE CONSTRUCTION ING   |        | COMI | E SURVEY<br>PLETED         |
|--------------------------|---|---|--------------------|--|--------|------|----------------------------|
|                          |   | 245438  | B. WING            |  |        | 11/1 | C<br>1 <b>8/2020</b>       |
|                          | PROVIDER OR SUPPLIER  | B CENTER  |                    | STREET ADDRESS, CITY, STATE, ZIP CO<br>1717 UNIVERSITY DRIVE SOUTHEAS<br>SAINT CLOUD, MN 56304 |        |      | 10,2020                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |  | SHOULD | BE   | (X5)<br>COMPLETION<br>DATE |
| F 600                    | command hallucina but acknowledged I times. Further, R2's which identified hig behavior(s) towards return to the nursing.  On 11/4/20, a progreturned from the Eincluding a urinalys negative for a bladd medication or treat. The note concluded practitioner] in 2 da  On 11/4/20, a subsidentified the pharm completed laborato his Clozapine [sic] in possible." The pharm contact the hospital results and would conote concluded, "We pharmacy." Further 11/4/20, identified to contacted. The pharmore information of been without his clohome expressed halast administration expressed they need who prescribed the to be re-titrated give been off the medical message had been | e my medicine." R2 denied tions to hurt himself or others, naving visual hallucinations at a clinical status was listed hly impulsive and aggressive to others. R2 was cleared to ghome.  The sess note identified R2 and had several labs, is completed. The results were der infection and no new ment orders were provided. The is to see [nurse ys."  The parmacist voiced they would to review the laboratory ontact the nursing home. The riter is awaiting call back from an additional note, dated he pharmacy was again reacist voiced they needed how many days R2 had ozapine; which the nursing ad been "two weeks since his" The pharmacist then eded to speak with the provider medication to see if it needed en the length of time R2 had ation. The pharmacist voiced a left for the provider, and the riter is awaiting a respond | F6                 | 600  |        |      |                            |

|                          | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |  | (X2) MUL<br>A. BUILD |     | (X3) DATE SURVEY COMPLETED C  |          |                            |
|--------------------------|---|--|----------------------|-----|---|----------|----------------------------|
|                          |   | 245438   | B. WING              |     |   |          | 18/2020                    |
|                          | PROVIDER OR SUPPLIER  | B CENTER   |                      | 171 | REET ADDRESS, CITY, STATE, ZIP CODE 7 UNIVERSITY DRIVE SOUTHEAST INT CLOUD, MN 56304                            | <u>,</u> | 10/2020                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG   | ×   | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE       | (X5)<br>COMPLETION<br>DATE |
| F 600                    | On 11/6/20, at 1:38 identified R2 was s approximately 11:3 he was going to ge When he didn't casked CNA to go smachine but CNA of from east [sic] and rooms and other ar found him raping a for help. The 2 mal walked him back to of nursing] and chapolice were called a [1:30 a.m.]. For moadult] report."  R2's Medication Acdated 10/2020 to 1 physician ordered r subsequent admini was listed for cloza everyday; which ha The medication was consumed by R2 ur 11/5/20, the MAR is doses of the medication was legend as, "Medication was l | ean. a progress note een coming out of his room at 0 p.m. (on 11/5/20) and voiced to a soda. The note continued, "come back in 15 minutes e if he was still by pop couldn't find him. Writer, nurse 2 CNA's split up to check all leas of the building [NA-A] female resident and screamed e CNA's pulled him off her and his room. The DON [director arge RN were called. The and the police took him about are details see VA [vulnerable]  Iministration Record (MAR), 1/2020, identified R2's medications and their stration record(s). An order pine 500 milligrams (mg) da listed start date of 6/25/20. Is recorded as being given and their stration record (s). From 10/21/20 to dentified nearly all subsequent ation were not given with of, "18," which was identified | F 6                  | 000 |   |          |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | ` ′   | TPLE CONSTRUCTION  NG |   | COMPLETED |                            |  |
|---|--|---|-----------------------|---|-----------|----------------------------|--|
|   |  | 245438  | B. WING _             |   | 4         | C<br>I/ <b>18/2020</b>     |  |
|   | PROVIDER OR SUPPLIER   | AB CENTER   |                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1717 UNIVERSITY DRIVE SOUTHEAST<br>SAINT CLOUD, MN 56304       |           | 1110/2020                  |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | JLD BE    | (X5)<br>COMPLETION<br>DATE |  |
| F 600   | Continued From pa  | age 17  | F 60                  | 00  |           |                            |  |
|   | behavior recorded as, "disrupted [the] re-directed but the The report lacked at the demonstrated so ther behaviors we reports despite the which identified him and wandering aro R2's medical recorevidence R2's esca  | sexually inappropriate on 11/2/20 which was outlined environment." R2 was intervention was ineffective. any further dictation on what sexual behavior was, and no ere recorded for R2 on these repeated progress note(s) in as cursing, throwing objects und the facility.  It was reviewed and lacked alating behaviors had been ssessed to help determine all |                       |   |           |                            |  |
|   | contributing factors to help reduce and abrupt stopping of medication. There had been impleme ensure R1 was add monitored to preveabuse towards or f being independent documentation of each stop in the stop in t | s and subsequent interventions for eliminate them despite the his prescribed antipsychotic was no evidence interventions nted on a consistent basis to equately supervised and ent altercations and potential from other residents despite R2 by mobile and ongoing escalating behaviors, including items, hallucinating and being                              |                       |   |           |                            |  |
|   | guardian (G)-A was had been involved year and explained home in June 2020 therapy after a hos R2's mentation as meds" and outlined well" before 10/19/refused his laborat to not be provided   | :22 p.m. R2's appointed s interviewed. G-A stated she in R2's care for over the past R2 admitted to the nursing for some rehabilitation pitalization. G-A described stable until he went off his she felt he was doing "quite 20. G-A expressed R2 had ory draw which is what led him his ordered antipsychotic beguently have worsening                        |                       |   |           |                            |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |  |           | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--|---|---|--|-----------|-------------------------------|--|
|   |  | 245438  | B. WING                                 |  | 11        | C<br>/ <b>18/2020</b>         |  |
|   | PROVIDER OR SUPPLIE  |   |   | STREET ADDRESS, CITY, STATE, ZIP CO<br>1717 UNIVERSITY DRIVE SOUTHEAS<br>SAINT CLOUD, MN 56304   | DDE       | 110/2020                      |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF CORF<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETION<br>DATE    |  |
| F 600   | behaviors. G-A voseen R2 to act wihe had in the wee subsequent disched. G-A then recalled 11/6/20 and him serident. G-A was masturbating in hexpressed the face regarding moving had previously be doorway of anoth inappropriate sex facility never provof him doing that verbally to her by not recall. G-A state of R2 refusing the subsequent holding medications, which nursing home should have been before sexually as stated R2 was cucharges pending assault which mathe entire escalate subsequent sexual could have been responded approphelieve this could R1's quarterly Mir 8/29/20, identified depression, and he short-term memo as having no spennever, able to under the subsequent sexual could have been responded approphelieve this could R1's quarterly Mir 8/29/20, identified depression, and he short-term memo as having no spennever, able to under the subsequent sexual could have been responded approphelieve this could R1's quarterly Mir 8/29/20, identified depression, and he short-term memo as having no spennever, able to under the subsequent sexual could be subsequent | page 18 Diced she had never known or the the demonstrated behaviors also prior to his arrest and arge from the nursing home. The events which led up to sexually assaulting another aware R2 had been found is room on 11/2/20, and then colity had contacted her R2 to a different room as he en witnessed standing in the er resident's room and "making ual comments." However, the ided the documentation to her as it had just been expressed a staff member whom she could atted she was not notified timely alaboratory draw, nor the eng of his antipsychotic ch was frustrating to her as the could have contacted her and he hospitalized or treated sooner assaulting someone. Further, G-A rently locked in jail with multiple against him from the sexual de her upset as she believed fon of R2's behaviors and all assault on another resident prevented if the facility had priately. G-A reiterated, "I have been prevented!"  Inimum Data Set (MDS), dated and both long-term and ry impairment. R1 was recorded each ability and was rarely, or derstand others verbally. The defence of the sexistance with red extensive assistance with | F 6                                     | 00   |           |                               |  |

|                          | OF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MUL <sup>*</sup><br>A. BUILDI | TIPLE CONSTRUCTION  ING   |                            | COM   | E SURVEY<br>PLETED         |
|--------------------------|--|--|------------------------------------|---|----------------------------|---|----------------------------|
|                          |  | 245438   | B. WING                            |   |                            |   | C<br>18/2020               |
|                          | PROVIDER OR SUPPLIER   | B CENTER   |                                    | STREET ADDRESS, CITY, STATE, 2 1717 UNIVERSITY DRIVE SOUT SAINT CLOUD, MN 56304 |                            | <u>, , , , , , , , , , , , , , , , , , , </u> | 10/2020                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                |   | TION SHOULD<br>THE APPROPI | BE  | (X5)<br>COMPLETION<br>DATE |
| F 600                    | her activities of dail R1's Social Service Collection/Assessm R1 had short and lowith severely impai capabilities. A staff her mood which ide down, depressed of of mood impairment section labeled, "Volidentified R1 demon bruises or injuries a towards others. The was unable to reporallegations and der would be indicative did not outline whice considered to make R1 was recorded a abuse from others. conclusion which re vulnerable but there with bolded font whice individual resident p findings. Plan shout the risk of abuse / r area identified in th resident's history w A series of generic listed to be selected chosen of, "Reside environment," and a were checked inclut discomfort and/or r safe environment; a potentially abusive | y living (ADLs).  s Data lent, dated 8/28/20, identified long-term memory impairment lored decision making lassessment was conducted of lentified no episodes of feeling lent hopeless or other indicators lentified no episodes of feeling lentified no belaviors listed a lunerability Review," which lentified no history of abuse lentified no behaviors which lentified no behaviors which lentified no behaviors which lentified no behaviors which lentified at risk for lentified at risk for lentified at risk for lentified at risk for lentified no signs of abuse," along lich outlined, "Further develop lentified no signs of abuse," along lich outlined, "Further develop lentified no prions for any lentified no prions were then lentified no prions were lentified no prio | F 6                                | 600   |                            |   |                            |

| AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  |                     |      | COMPLETED   |       |                            |
|--|--|--|---------------------|------|---|-------|----------------------------|
|  |  | 245438   | B. WING             |      |   |       | C<br><b>18/2020</b>        |
|  | PROVIDER OR SUPPLIER   | B CENTER   |                     | 1717 | UNIVERSITY DRIVE SOUTHEAST IT CLOUD, MN 56304   | 1 11/ | 10/2020                    |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | ×    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPI<br>DEFICIENCY) | BE    | (X5)<br>COMPLETION<br>DATE |
| F 600  | observation." The aidentified interventicall for help or repordecks on a routing when not providing R1's care plan, date considered vulneral physical impairment which read, "Reside environment," along which directed to old discomfort or mental environment, and, abusive situations. interventions listed 11/6/20 to help ensidespite being identificate Data Collection Assibeing unable to repabuse from others.  On 11/13/20, at 9:0 (FM)-A was interview from 11/5/20. FM-A another resident (Rand was "caught in her. R1 was transpalled a "rape kit" was corbeen sexually assaland bruising on R1 resident "had pinned her. FM-A expressed perpetrator had begallowed to come base Further, FM-A states | essessment lacked any ons specific to R1's inability to out abuse (i.e. formal safety espasis, doorway left open care, etc.).  ed 11/6/20, identified R1 was ble due to cognitive and its. The care plan listed a goal ent will be provided a safe gwith three interventions observe for potential pain, all anguish; provide a safe remove R2 from potentially. These were the only on the care plan prior to ure R1 remain free of abuse ified on her Social Services dessment (dated 8/28/20) as nort abuse and being at risk for explained he had been told in explained which verified R1 had ulted as they found injuries its arms where the other in each in the act in the alleged in arrested and was "no longer inck" to the nursing home. In closer to the nurses station in closer to the nurses station | F 6                 | 00   |   |       |                            |

|                          | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | 1 ' '               | TIPLE CONSTRUCTION ING   |                         |   | E SURVEY<br>PLETED         |
|--------------------------|---|--|---------------------|--|-------------------------|---|----------------------------|
|                          |   | 245438   | B. WING             |  |                         | l   | C<br><b>18/2020</b>        |
|                          | PROVIDER OR SUPPLIER  | B CENTER   |                     | STREET ADDRESS, CITY, STATE, ZII<br>1717 UNIVERSITY DRIVE SOUTH<br>SAINT CLOUD, MN 56304 |                         | <u>, , , , , , , , , , , , , , , , , , , </u> | 10/2020                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)                                    | ID<br>PREFIX<br>TAG |  | ON SHOULD<br>HE APPROPI | BE  | (X5)<br>COMPLETION<br>DATE |
| F 600                    | R1's medical record On 11/6/20, a progressident incident." home on the same R1's corresponding Community Care P R1 had been transport of Assault" was listed location of the nurs labeled, "Patient De outlined which iden gathered from NA-/ Police Department room by [NA-A], be assailant. Assailant arms it took 3 sta off of patient report thrusting in and out minutes." The report up with nursing care (used to make patie procedures) was gi grinding her teeth of the report dictated, that [R1] grinds her distress." The report petechiae (pinpoint the skin as a result to localized trauma elbow region. The re examination was co reddened cervix, ar and hymen, and a l On 11/6/20, a subs | d identified the following: ress note identified R1 had left ation "after resident to R1 returned to the nursing | F 6                 | 500  |                         |   |                            |

|                          | F OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` ′                |     | CONSTRUCTION   | COM          | E SURVEY<br>IPLETED        |
|--------------------------|--|---|--------------------|-----|--|--------------|----------------------------|
|                          |  | 245438  | B. WING            |     |  |              | C<br>1 <b>8/2020</b>       |
|                          | PROVIDER OR SUPPLIER   |   |                    | 17  | REET ADDRESS, CITY, STATE, ZIP CODE  17 UNIVERSITY DRIVE SOUTHEAST  AINT CLOUD, MN 56304                         | <u>, 11/</u> | 10/2020                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE           | (X5)<br>COMPLETION<br>DATE |
| F 600                    | contacted FM-A w services for R1. F accepted moving F was closer to the r more important that On 11/7/20, a progentered R1's room continued, "During teary-eyed with so Resident was obsefrequently. Oxycoorelax resident."  On 11/10/20, a profor psychiatric servevaluate and treat Associated Clinic of Assessment, date telephone visit was R1's traumatic resussault by R2 with recently sexually a and staff ask for paddress ongoing to that may come to listed several recoincluded having or for startle responsinursing station. Hollacked any evident vulnerability to conresiding at the nursual on 11/13/20, at 9: and explained R1 staff to complete having the responsing staff to complete having explained R1 staff to comp | hom consented for psychiatric urther, FM-A was offered and R1 to a different room which pursing station as " safety is an anything."  gress note identified a nurse and comforted her. The note this resident noted to get me tears falling from face. Erved to be grabbing at brief lone was administered to help of Psychology (ACP) Diagnostic of 11/9/20, identified a conducted to help evaluate ponse following the sexual dictation reading, "[R1] was saulted by a male resident expendigned as sexual dictations for R1 which ally female caregivers, observing es, and being closer to the owever, the completed report assessment of R1's tinued abuse by others while |                    | 600 |  |              |                            |

| STATEMENT                | OF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                   |     | LE CONSTRUCTION  |              | E SURVEY<br>IPLETED        |  |
|--------------------------|--|--|-------------------|-----|--|--------------|----------------------------|--|
|                          |  | 045400   |                   |     |  |              | С                          |  |
|                          |  | 245438   | B. WING           |     |  | <u>  11/</u> | 18/2020                    |  |
|                          | PROVIDER OR SUPPLIER  NURSING AND REHA   | B CENTER   |                   | 1   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1717 UNIVERSITY DRIVE SOUTHEAST<br>SAINT CLOUD, MN 56304        |              |                            |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE           | (X5)<br>COMPLETION<br>DATE |  |
| F 600                    | walk down to the so "about 15 minutes" (RN-B) had asked she had "been acting had not returned ye search was started other staff member While helping search walked by R1's clospause and check ir left open at night as call for assistance, eye on her room. Nand saw R2 on toppants or underwear hands [down] on to her." NA-A express removed and R2's immediately above down." NA-A stated to "get off of her," bat NA-A while he could be the man back into the for help from the m standing in the hall removed R2 from Froom. NA-A explair and R2 was subsequirising home. Furt never known R2 to prior, but verified he supervision or mon as "acting weird" the When interviewed in RN-B stated R1 was typically remained in the standing in the hall removed R2 from Froom. NA-A explair and R2 was subsequirising home. Furt never known R2 to prior, but verified he supervision or mon as "acting weird" the When interviewed in RN-B stated R1 was typically remained in the supervision or mon as "acting weird" the way typically remained in the supervision or mon as "acting weird" the way typically remained in the supervision or mon as "acting weird" the way typically remained in the supervision or mon as "acting weird" the way typically remained in the supervision or mon as "acting weird" the way typically remained in the supervision or mon as "acting weird" the way typically remained in the supervision or mon as "acting weird" the way typically remained in the supervision of the supervision or mon as "acting weird" the way typically remained in the supervision of the supervisio | n and voiced he was going to oda machine. R2 was gone for when the nurse working staff to start looking for R2 as gweird the last few days" and et. NA-A stated a facility-wide involving herself and several including NA-B and RN-A. In for R2, NA-A stated she sed room door which made her reside as R1's door was usually so staff tried to keep a closer A-A opened R1's closed door of R1 in her bed. R2 had no on and was "holding her pof her" and "having sex with led R1's brief had been maked buttocks were visible her peri-area "moving up and if she immediately yelled at R2 but R2 just turned and looked ontinued assaulting R1. NA-A the hallway and called out loud ale staff members who were way. They responded and R1's bed and took him to his ned the police were contacted quently removed from the her, NA-A explained she had demonstrate sexual behaviors is was not on any formal itoring despite being identified | F                 | 300 |  |              |                            |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |                      | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:    | l ' '      |     | PLE CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |                    |
|---|----------------------|---|------------|-----|---|-------------------------------|--------------------|
|   |                      |   |            |     |   | (                             | C                  |
|   |                      | 245438  | B. WING    |     | <del> </del>  | 11/                           | 18/2020            |
| NAME OF F   | PROVIDER OR SUPPLIER |   |            |     | STREET ADDRESS, CITY, STATE, ZIP CODE                           | ·                             |                    |
| TAL ALII  | NUIDOING AND DELLA   | D CENTED  |            | ,   | 1717 UNIVERSITY DRIVE SOUTHEAST                                 |                               |                    |
| IALAHII   | NURSING AND REHA     | AB CENTER   |            | ,   | SAINT CLOUD, MN 56304   |                               |                    |
| (X4) ID<br>PREFIX                                   | (EACH DEFICIENC)     | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL | ID<br>PREF |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD | BE                            | (X5)<br>COMPLETION |
| TAG   | REGULATORY OR L      | SC IDENTIFYING INFORMATION)                           | TAG        |     | CROSS-REFERENCED TO THE APPROPI<br>DEFICIENCY)                  | RIATE                         | DATE               |
| F 600   | Continued From pa    | age 24  | F 6        | 300 |   |                               |                    |
|   | · ·                  | ry two hours." RN-B described                         |            |     |   |                               |                    |
|   |                      | no "didn't need much care" and                        |            |     |   |                               |                    |
|   |                      | round the nursing home at                             |            |     |   |                               |                    |
|   |                      | R2 was not known to enter                             |            |     |   |                               |                    |
|   |                      | oms to her knowledge. RN-B                            |            |     |   |                               |                    |
|   |                      | cident involving R1 and R2                            |            |     |   |                               |                    |
|   |                      | explained R2 had come out of                          |            |     |   |                               |                    |
|   |                      | ed he was going to walk to the                        |            |     |   |                               |                    |
|   |                      | did not return after 15 to 20                         |            |     |   |                               |                    |
|   |                      | asked the floor staff to look for                     |            |     |   |                               |                    |
|   |                      | to make sure R2 did not                               |            |     |   |                               |                    |
|   |                      | er onto the COVID-19 unit.                            |            |     |   |                               |                    |
|   |                      | unable to find him after                              |            |     |   |                               |                    |
|   |                      | mons areas, so she directed                           |            |     |   |                               |                    |
|   |                      | hecking each resident's room.                         |            |     |   |                               |                    |
|   |                      | ng rooms on the North hallway                         |            |     |   |                               |                    |
|   |                      | er [NA-A] scream" and                                 |            |     |   |                               |                    |
|   |                      | hen told her R2 was found in                          |            |     |   |                               |                    |
|   |                      | cribed the incident. R2 was                           |            |     |   |                               |                    |
|   |                      |   |            |     |   |                               |                    |
|   |                      | rted back to his room, and                            |            |     |   |                               |                    |
|   |                      | nmediately contacted the DON                          |            |     |   |                               |                    |
|   |                      | instructions on how to handle                         |            |     |   |                               |                    |
|   |                      | police department was                                 |            |     |   |                               |                    |
|   |                      | oonded whom then interviewed                          |            |     |   |                               |                    |
|   |                      | n told RN-B that R2 had                               |            |     |   |                               |                    |
|   |                      | one it" and was then removed                          |            |     |   |                               |                    |
|   |                      | ome. RN-B recalled R2 never                           |            |     |   |                               |                    |
|   |                      | ated any hallucinatory or                             |            |     |   |                               |                    |
|   |                      | ors which she could recall,                           |            |     |   |                               |                    |
|   |                      | 2 had seemed to become                                |            |     |   |                               |                    |
|   |                      | he weeks leading up the                               |            |     |   |                               |                    |
|   |                      | d R2's subsequent discharge                           |            |     |   |                               |                    |
|   |                      | ome. RN-B stated she was "not                         |            |     |   |                               |                    |
|   |                      | pecome more restless and                              |            |     |   |                               |                    |
|   |                      | sn't aware" there had been                            |            |     |   |                               |                    |
|   |                      | lining him as being aggressive                        |            |     |   |                               |                    |
|   |                      | or to the incident on 11/5/20;                        |            |     |   |                               |                    |
|   |                      | ned of the notes since he was                         |            |     |   |                               |                    |
|   |                      | ved from the nursing home.                            |            |     |   |                               |                    |

|                          | OF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                  | (X2) MUL <sup>*</sup><br>A. BUILDI |     | CONSTRUCTION   | (X3) DATE COMP |                            |
|--------------------------|--|--|------------------------------------|-----|--|----------------|----------------------------|
|                          |  | 245438   | B. WING                            |     |  |                | C<br>18/2020               |
|                          | PROVIDER OR SUPPLIER   | B CENTER   |                                    | 171 | EET ADDRESS, CITY, STATE, ZIP CODE 7 UNIVERSITY DRIVE SOUTHEAST INT CLOUD, MN 56304                              | 1 11/          | 10/2020                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)           | ID<br>PREFIX<br>TAG                | <   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE             | (X5)<br>COMPLETION<br>DATE |
| F 600                    | education on how to the facility's abuse incident had happe. During interview on LPN-A stated he wand described R2 aresident who mainly often stayed in his incident from 11/5/2 on the locked unit wapproached him and who had not return stated he offered to when he heard NA-hallway, "He's rapir immediately ran do witnessed R2 on to pants, boxers and sgown was pulled up opened. LPN-A state penetrating R1, but top of her [R1] with vagina." LPN-A add sure" to have sexual had not already. R2 from R1 and they eand told him his be "totally inappropriat was unaware of an guidance the facility assault; however, a meeting coming up "hoping we're going assault incident]." | ed she had not received any on handle sexual assaults or prevention policies since the | F 6                                | 00  |  |                |                            |

|                          | OF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MUL <sup>*</sup><br>A. BUILDI | TIPLE CONSTRUC | CTION   |        | COM   | E SURVEY<br>PLETED         |
|--------------------------|--|--|------------------------------------|----------------|---|--------|-------|----------------------------|
|                          |  | 245438   | B. WING                            |                |   |        |       | C<br>18/2020               |
|                          | PROVIDER OR SUPPLIER   | B CENTER   |                                    | 1717 UNIVER    | RESS, CITY, STATE, ZIP CO<br>SITY DRIVE SOUTHEA:<br>UD, MN 56304                      |        | 1 11/ | 10/2020                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                | (EAC           | ROVIDER'S PLAN OF COR<br>CH CORRECTIVE ACTION<br>S-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD | BE    | (X5)<br>COMPLETION<br>DATE |
| F 600                    | sexually assaulted being non-verbal ar her physical impairs being able to physicassailant.  On 11/13/20, at 1:0 manager (RN)-A ar (LSW)-A were interadmitted to the nurshospitalization and venue of less care R2 as "calm and reidentified him to haweeks leading up to 11/5/20. LSW-A ex reviewed a resident quarterly basis usin with a daily review of stand-up meeting. Progress note (date displayed no halluct behaviors at that tir concerns" with him were actually unsur him as having restimeeting. LSW-A standering. RN-A contacted R2's nursur days later (on 10/22 feel comfortable standays later (on 10/22 feel comfortable standays later standays later (on 10/22 feel comfortable standays later standays l | vulnerability since being by R2 on 11/5/20, despite R1 and unable to report abuse or ment(s) resulting in a lack of cally fight against a potential 7 p.m. registered nurse and licensed social worker viewed. They explained R2 | F 6                                | 00             |   |        |       |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |                      | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:    | ` ′         |     | E CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |                     |
|---|----------------------|---|-------------|-----|---|-------------------------------|---------------------|
|   |                      | 245438  | B. WING     |     |   |                               | C<br><b>18/2020</b> |
| NAME OF F   | PROVIDER OR SUPPLIER | 1   | <u> </u>    | S   | TREET ADDRESS, CITY, STATE, ZIP CODE  |                               | 10/2020             |
| TALAHI  | NURSING AND REHA     | AB CENTER   |             |     | 717 UNIVERSITY DRIVE SOUTHEAST<br>SAINT CLOUD, MN 56304   |                               |                     |
| (X4) ID<br>PREFIX                                   | (EACH DEFICIENC      | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL    | ID<br>PREFI | X   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE |                               |                     |
| TAG   | REGULATORY OR I      | LSC IDENTIFYING INFORMATION)                          | TAG         |     | DEFICIENCY)   | TATE                          | DATE                |
| F 600   | Continued From pa    | age 27  | F 6         | ററ  |   |                               |                     |
|   |                      | R2's psychiatry team should be                        |             | ,00 |   |                               |                     |
|   |                      | as possible. RN-A stated she                          |             |     |   |                               |                     |
|   |                      | contact the psychiatric team via                      |             |     |   |                               |                     |
|   |                      | er, was unable to reach anyone                        |             |     |   |                               |                     |
|   |                      | age. A return call was never                          |             |     |   |                               |                     |
|   |                      | nd RN-A verified she never                            |             |     |   |                               |                     |
|   |                      | contact the psychiatry provider                       |             |     |   |                               |                     |
|   |                      | e "didn't feel anybody was in                         |             |     |   |                               |                     |
|   | immediate danger.    | " They verified no increased                          |             |     |   |                               |                     |
|   |                      | nitoring had been placed on R2                        |             |     |   |                               |                     |
|   |                      | opping his antipsychotic                              |             |     |   |                               |                     |
|   |                      | er, RN-A added such an                                |             |     |   |                               |                     |
|   |                      | be a good intervention to do                          |             |     |   |                               |                     |
|   |                      | abruptly ceased their                                 |             |     |   |                               |                     |
|   |                      | and LSW-A then reviewed R2's                          |             |     |   |                               |                     |
|   |                      | d progress notes. They                                |             |     |   |                               |                     |
|   |                      | aviors being recorded after                           |             |     |   |                               |                     |
|   |                      | normal behaviors R2 had                               |             |     |   |                               |                     |
|   |                      | r, and expressed no                                   |             |     |   |                               |                     |
|   |                      | cussion of them had occurred                          |             |     |   |                               |                     |
|   |                      | up meeting(s). RN-A voiced the                        |             |     |   |                               |                     |
|   |                      | nenting the behaviors should                          |             |     |   |                               |                     |
|   |                      | e management team was                                 |             |     |   |                               |                     |
|   |                      | l added they had "definitely not"                     |             |     |   |                               |                     |
|   |                      | hese behaviors including the                          |             |     |   |                               |                     |
|   |                      | sical aggression and                                  |             |     |   |                               |                     |
|   |                      | V-A stated she did not "feel like e behaviors" R2 was |             |     |   |                               |                     |
|   |                      | e benaviors R2 was<br>en recalled the incident        |             |     |   |                               |                     |
|   |                      | R2 from 11/5/20. LSW-A stated                         |             |     |   |                               |                     |
|   |                      | by a maintenance man who                              |             |     |   |                               |                     |
|   |                      | /1/20 at the front desk that R2                       |             |     |   |                               |                     |
|   |                      | nding outside R1's room. R2                           |             |     |   |                               |                     |
|   |                      | ating behaviors at the time,                          |             |     |   |                               |                     |
|   |                      | ely just observed standing                            |             |     |   |                               |                     |
|   | there and staring in |   |             |     |   |                               |                     |
|   |                      | was then found masturbating,                          |             |     |   |                               |                     |
|   | •                    | ecorded progress notes, on                            |             |     |   |                               |                     |
|   |                      | ated they had not ever                                |             |     |   |                               |                     |

|                          | FOF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                | LTIPLE CONSTRUCTION DING  |                                   | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|---|--|--------------------|---|-----------------------------------|-------------------------------|--|
|                          |   | 245438   | B. WING            | j   | 11                                | C<br>/ <b>18/2020</b>         |  |
|                          | PROVIDER OR SUPPLIE   |  |                    | STREET ADDRESS, CITY, STATE, Z<br>1717 UNIVERSITY DRIVE SOUT<br>SAINT CLOUD, MN 56304 | ZIP CODE                          |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN  | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |   | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETION<br>DATE    |  |
| F 600                    | considered and a behaviors R2 had abruptly stopped medication. RN-A updated on the behappening, they were comprehensive at the situation "a little added she "didn't escalating like the contacted the fact tried to include the these crazy behano changes were from a room char incident involving "maybe some edi RN-A stated staff policies and proceed pressed a mee of R1 and the missisterior in the second proceed in the | I since 10/19/20 when he taking his antipsychotic reiterated if they had been chaviors and known they were would have done some "more ssessment" of them and taken the more seriously." LSW-A know the behaviors were at and voiced she would have ility's psychiatry team (ACP) and them "if we [had been] aware of viors." RN-A and LSW-A verified made to R2's care plan, aside ange, from 10/19/20 until the R1 on 11/5/20 and added ucation" was needed. Further, received training on abuse redures when they're hired and ting to review the sexual assault ased behavior monitoring on R2 ething "we need to address" in | F6                 | 600   |                                   |                               |  |
|                          | described R2 as reserved" and "qu verified she was 'prior to the clozar explained she did R2's clozapine as have a special ce dangerous medic certain laboratory periodically and, a even release the were obtained. As stated R2's psych   | d on 11/13/20, at 3:12 p.m. NP-B someone who was "very liet" prior to 10/19/20, and NP-B not aware of any behaviors" oine being stopped. NP-B not personally order or manage the prescriber is required to rtification as it was "a very ation." The medication required values to be checked at times, pharmacies would not medication until these lab(s) is a result of those things, NP-B niatry team was managing his a NP-B explained when R2   |                    |   |                                   |                               |  |

|                          | FOF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                 | TIPLE CONSTRUCTION ING   | L COM                    |    | E SURVEY<br>PLETED         |
|--------------------------|---|--|---------------------|--|--------------------------|----|----------------------------|
|                          |   | 245438   | B. WING             |  |                          | 1  | C<br>18/2020               |
|                          | PROVIDER OR SUPPLIER  NURSING AND REHA  | B CENTER   |                     | STREET ADDRESS, CITY, STATE, Z<br>1717 UNIVERSITY DRIVE SOUTH<br>SAINT CLOUD, MN 56304 |                          |    |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG |  | ION SHOULD<br>HE APPROPI | BE | (X5)<br>COMPLETION<br>DATE |
| F 600                    | refused the laborate their on-call provide a couple days later new medication or assumed the nursing touch with R2's psychave "no idea" what 10/31/20, NP-B stated the time, a three (3 medication used for on 11/3/20, NP-B was now being very "two weeks" without NP-B stated this way had not had his closordered him to be a nursing home felt thanymore. The ED of laboratory draw(s) and notified of his refusion and subsequence on clonazepam soon helped to calm and he required treatments sexually assaulted.  On 11/13/20, at 3:3 pharmacist (CP) was clozapine was a moother antipsychotics. | ory monitoring on 10/19/20, or service was notified about it on 10/22/20. NP-B voiced no ders were given as she ing home had already been in rehiatry team and she would it they did or did not order. On ted they were again notified med to be worsening and, at it is did not order. On ted they were again notified med to be worsening and, at is did not order. On ted they were again notified med to be worsening and, at is did not order. On ted they were again and told R2 is a notified med to be worsening and told R2 is a notified med to he realized he again and told R2 is a notified med to her working on getting his when he returned to the interpretation of the NP-B expressed she was not altry team had never been alto allow the laboratory quent holding of his clozapine infortunate." Further, NP-B is een told R2's psychiatry on updated and R2 had started oner, it may "potentially" have reduce R2's behaviors before ent in the ED and subsequently | F 6                 | 00   |                          |    |                            |

|                          | PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COM   |   | TE SURVEY<br>MPLETED |  |         |                            |
|--------------------------|---|---|----------------------|--|---------|----------------------------|
|                          |   | 245438  | B. WING              |  | 11      | C<br>/18/2020              |
|                          | PROVIDER OR SUPPLIER  |   |                      | STREET ADDRESS, CITY, STATE, ZIP COD<br>1717 UNIVERSITY DRIVE SOUTHEAST<br>SAINT CLOUD, MN 56304 | E       | 710,2020                   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRE ( (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)   | OULD BE | (X5)<br>COMPLETION<br>DATE |
| F 600                    | special laboratory while the patient is wouldn't be a good medication without doing so could yiel schizophrenia symeffects. Further, Cithe specifics regar clozapine medicati had stopped taking then had a return odifferent antipsych symptoms may hanursing home show when the patient readdress it.  On 11/17/20, at 11 (DON) was interview administrator was for interview. The I telephone call show and the staff voice happened." They et o get a soda which "normal" for him to times; however, af return so a facility-staff then told her to contact the police contacted and updallegation. R1's gu was sent to the hone, the police was going to be an as R2 admitted to | age 30 monitoring to ensure safety on it. CP voiced it "probably idea" to abruptly stop the slowly titrating down prior, and d the sudden return of ptoms or other adverse P stated she was unaware of ding R2 and his missed on; however, explained if he g the medication abruptly and of symptoms that perhaps a otic to help reduce or calm the ve helped. CP added the uld have a policy on what to do efuses medications and how to  32 a.m. the director of nursing ewed and verified the off campus and not available DON explained she received a rtly after midnight on 11/6/20, d "something terrible has explained R2 had left his room in the DON described as be "out and about" the unit at ther several minutes he did not wide search was started. The ethey found R2 and he was at]." The DON instructed them are department and then atted the administrator on the ardian was contacted and she espital for examination. The she arrived at the nursing are present and voiced R2 rested for "sexual misconduct" the police he committed the DON said nobody provided | F 6                  | 00   |         |                            |

| · · · · · · · · · · · · · · · · · · ·  | PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | l ` ′               | FIPLE CONSTRUCTION  NG  | (        | (X3) DATE SURVEY<br>COMPLETED |                            |
|--|--|---------------------|---|----------|-------------------------------|----------------------------|
|  | 245438   | B. WING             |   |          | 11/1                          | C<br>18/2020               |
| NAME OF PROVIDER OR SUPPLIER   |  | 1                   | STREET ADDRESS, CITY, STATE, ZIP C  | ODE      | 1 1/                          | 10/2020                    |
| TALAHI NURSING AND REHAB CE  | ENTER  |                     | 1717 UNIVERSITY DRIVE SOUTHEA<br>SAINT CLOUD, MN 56304  | ST       |                               |                            |
| PREFIX (EACH DEFICIENCY MUS  | INT OF DEFICIENCIES<br>T BE PRECEDED BY FULL<br>ENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE /<br>DEFICIENCY) | SHOULD E | 3E                            | (X5)<br>COMPLETION<br>DATE |
| the DON verified R1's fir injuries on her skin and were not present prior to 11/5/20. The DON then the nursing home were reded from the allegation with the surveyor which  On 11/5/20, at 11:24 p.r. the camera and walks p his head and looks back the corner to go down the where R1 resides. The I his head to look at NA-E [her]." R2 then walks do seen entering R1's room doorway to R1's room is however, the DON verification doorway immediately aff Approximately 15-20 sevisible coming around the past R1's room without shoom. At 11:48 p.m. NA-room and does not stop the doorway being close minutes after R2 entered visible entering R1's room immediately comes back gesturing to the staff state the hallway. The staff ruant 11:57 p.m. R2 is visib R1's room wearing only escorting him hold a tow waist. There is no record of the video clips.  The interview with the D | ned from the hospital and ndings, including the vaginal examination, of the sexual assault on verified the hallway(s) of video monitored and the time-frame was reviewed revealed the following:  m. R2 comes visible into last NA-B. R2 then turns of at NA-B before he turns he section of hallway DON voiced R2 turning a looked "suspicious to lawn the hallway and is not visible in the feed; and the feed the entered the room. Conds later, NA-B is no corner and walking stopping or looking at the lagain walks by R1's or enter the room despite led. At 11:56 p.m. (31 d R1's room) NA-A is large mand almost k into the hallway while landing down at the end of land to R1's room and enter. Die being escorted out of a shirt as the staff vel over his genitals and ded sound for the entirety | F 6                 |   |          |                               |                            |

|                          |  |   | E SURVEY<br>PLETED  |   |                          |    |                            |
|--------------------------|--|---|---------------------|---|--------------------------|----|----------------------------|
|                          |  | 245438  | B. WING             |   |                          |    | C<br><b>18/2020</b>        |
|                          | PROVIDER OR SUPPLIER   | B CENTER  |                     | STREET ADDRESS, CITY, STATE, ZI<br>1717 UNIVERSITY DRIVE SOUTH<br>SAINT CLOUD, MN 56304 |                          |    | 10/2020                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF C<br>X (EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO TI<br>DEFICIENCY | ION SHOULD<br>HE APPROPF | BE | (X5)<br>COMPLETION<br>DATE |
| F 600                    | hospital records, the misconduct" had har raped her [R1]." Will action(s) taken to poseen by the mainted outside R1's room the staff reported to creepy" and had be vicinity of R1's room maintenance staff of standing by "the little voiced it was hard to standing at R1's doold room was closed not react abruptly to someone as "creep comment by itself, move R2 to a differ R2 to have altercated bathroom or televishappened in the pareviewed camera for 11/5/20, and they will incident of R2 standing accurately verified no formal swere placed on R2 his antipsychotic mescalating behavior standing outside R3 The DON stated may not be consider have been doing the before; however, standwelding of him before; however, standwelding of him before the properties of the prope | direct care staff and R1's ey determined "sexual appened and added, "He [R2] nen questioned on the rotect R1 when R2 had been nance personnel standing on 11/1/20, the DON explained ther on 11/2/20 that R2 "was sen seen standing in the n. The DON expressed the described it as R2 was e girls room." The DON o determine if R2 was actually or or just by her room as R2's to hers and added they did the comment as just voicing by isn't an overly concerning. However, they then decided to ent room as they didn't want it isns with roommates over the iten volume which had st. The DON stated they had botage since the incident on were unable to locate the ding outside R1's room despite an reporting it had happened dif he was reporting the st. Regardless, the DON upervision or safety checks despite him abruptly stopping edication, having documented as and potentially being found al's room and staring at her. asturbation, in itself, may or ered behavioral as he could e act in private many times ne did voice she had no being found doing it by staff prior to 11/2/20. The DON | F6                  |   |                          |    |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULT<br>A. BUILDIN   | IPLE CONSTRUCTION IG | CON  | (X3) DATE SURVEY<br>COMPLETED |                            |
|--|---|---|----------------------|--|-------------------------------|----------------------------|
|  |   | 245438  | B. WING _            |  |                               | C<br>/ <b>18/2020</b>      |
|  | PROVIDER OR SUPPLIER  |   |                      | STREET ADDRESS, CITY, STATE, ZIP O<br>1717 UNIVERSITY DRIVE SOUTHEA<br>SAINT CLOUD, MN 56304 | CODE                          | 110/2020                   |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY)   | N SHOULD BE                   | (X5)<br>COMPLETION<br>DATE |
| F 600  | behaviors to their "unpredictable" at if irritated. The DC heard about R2 no clozapine when st and a nurse repor medication to give confident" she had week just prior to a DON voiced her e be informed the sa laboratory draw ar medication not pro staff to ensure the updated on the sit several times to di tests, but R2 woul reviewed R2's pro record verified the documented" after expectation was for the progress notes concerns, like esc medications, to the reviewed and add possible triggers, DON verified R2's were never raised explained had the meeting, she "wou sure appropriate a and LSW-A were behaviors were as together." The DO would have lead to could have then be residents, includin | age 33 I no prior history of sexual knowledge, but rather he was times and would be aggressive on then explained she had of getting his scheduled anding out by the nurses station ted they did not have the adding she was "pretty of not been told of it until the the sexual assault of R1. The expectation would have been to ame day R2 initially refused the not subsequently had his ovided, and stated she directed guardian and NP-B were uation. The staff attempted raw the needed laboratory of not allow it. The DON then gress note(s) in his medical re were "more behaviors or RN-A and LSW-A to review of "each day" and bring alating behaviors and missed to IDT meeting so they can be ressed including reviewing for coatterns and other issues. The missed doses of clozapine at their IDT meetings and issues been presented at the all have intervened" and made action was taken adding RN-A responsible to ensure the esessed and "put all that the stated those assessments of multiple interventions which een attempted to help ensure g R2 himself, were kept safe in his escalating behaviors. The | F 60                 |  |                               |                            |

|                          | OF DEFICIENCIES OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | A. BUILDING         | PLE CONSTRUCTION  G   | COV    | TE SURVEY<br>MPLETED       |
|--------------------------|---|--|---------------------|---|--------|----------------------------|
|                          |   | 245438   | B. WING             |   |        | C<br>/ <b>18/2020</b>      |
|                          | PROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1717 UNIVERSITY DRIVE SOUTHEAST<br>SAINT CLOUD, MN 56304         |        | 10/2020                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | JLD BE | (X5)<br>COMPLETION<br>DATE |
| F 600                    | DON stated she for subsequent sexual been avoided since sexual behaviors a female resident rocould have predict she had just company RN-A and LSW-A behavioral monitor however, they had "more formal" edustaff as they were through their IDT.  A provided SA 'Five 11/12/20, identified investigation they identified the facilic care plans, diagnostatus in their inveations implemented. The interviewed six other residents for concresidents in their reconcerns; and, five had a skin assess monitoring for more help screen for poidentified this as "a continued with dictinvestigation also timely and appropris implausible that known to have been incident." Further, | age 34 elt the escalating behaviors, and I assault of R1, could not have e R2 had never displayed and had no history of entering oms it was not "something we ed." Further, the DON voiced eleted some education with on her expectations for ring and progress note review; not started any audits or other cation with other nurses and going to review everything  re-Day' investigation, dated d the facility' completed submitted to the SA. This report the fact and reviewed R1 and R2's eses, charting and cognitive estigation into the allegation. Its listed as being followed at the at and listed the ACP (dated 11/9/20) as being report identified LSW-A ther "alert and orientated" erns with any unwanted male form and all six denied er cognitively impaired residents ment completed, and and pain implemented, to tential concerns. The report a one-time incident," and that it interventions could have been en put into place to avoid this the report identified R1 was the fifthe sexual assault and R2 to the s | F 600               |   |        |                            |

|                          | OF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` ′                | TIPLE CONSTRUCTION  NG                                    |   |  | E SURVEY<br>PLETED |
|--------------------------|--|---|--------------------|---|---|--|--------------------|
|                          |  | 245438  | B. WING            |   |   | 11/1                                       | C<br>18/2020       |
|                          | PROVIDER OR SUPPLIER   |   |                    | STREET ADDRESS, CITY 1717 UNIVERSITY DRI'S AINT CLOUD, MN | VE SOUTHEAST  | 117  | 10/2020            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | NTEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG | ( (EACH CORRE)<br>CROSS-REFEREN                           | S PLAN OF CORRECTION<br>CTIVE ACTION SHOULD<br>NCED TO THE APPROPE<br>DEFICIENCY) | E ACTION SHOULD BE<br>D TO THE APPROPRIATE |                    |
| F 600                    | had been discharge the completed inveor information on Rebehaviors or what, implemented to adassault; nor did the facility had comprevulnerability to pote abuse, from others she remained adec.  When interviewed of maintenance staff of the front desk on 1 roaming in the hallowoiced R2 was "a lithe NA(s) working often. M-A said he then and from there watch him. M-A voi R2 standing outside his English was positioned it a little hard others.  On 11/17/20, at 1:5 were interviewed a vulnerability to abuse routinely" by the so part of their followithey had R1 seen to psychiatric service with other female reexperienced an "ur DON stated the nur on completing skin injuries on people was suspicious for abuse of the standard process. | ed from the facility. However, stigation lacked any evidence (2's documented, escalating if any, interventions had been dress them prior to the sexual report have any evidence the hensively reassessed R1's ential abuse, including sexual and their actions to ensure quately supervised and safe.  In 11/17/20, at 9:08 a.m. In 1/17/20, at 9:08 a.m. In 1/1/20, and recalled seeing R2 way "around 6:00 a.m." M-A title bit creepy," so he asked why R2 roamed around so merely reported R2 to the NA is it was "her responsibility" to ced he did not recall seeing a of R1's doorway, but added for, at times, and he sometimes in the book and to describe something to the sexual assault of R1, by their facility' contracted and they focused on visiting esidents on if they had a wanted interactions." The raing department was focusing assessments to rule out which may be consistent or se. LSW-A explained the routine vulnerability | F6                 | 00  |   |  |                    |

|                          | FOF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MUL <sup>*</sup><br>A. BUILDI | TIPLE CONSTRUCTION NG   |                         |                            | E SURVEY<br>PLETED |
|--------------------------|---|---|------------------------------------|---|-------------------------|----------------------------|--------------------|
|                          |   | 245438  | B. WING                            |   |                         |                            | C<br>18/2020       |
|                          | PROVIDER OR SUPPLIER  | B CENTER  |                                    | STREET ADDRESS, CITY, STATE, ZIP CODE  1717 UNIVERSITY DRIVE SOUTHEAST  SAINT CLOUD, MN 56304 |                         |                            | 10/2020            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY                 | ON SHOULD<br>HE APPROPF | (X5)<br>COMPLETION<br>DATE |                    |
| F 600                    | determine if abuse was at risk for abust things" such as ser someone was able However, LSW-A the formally reassesses since the incident or remained free of at facility's contracted reviewed R1 since recommendations of female only careging documentation lack vulnerability to abust she felt the "bigges her stay safe was the tothe nurses station reassessment of he benefit and would have pR1 safe were potential safety ches he "had not seen the | was present or if someone was present or if someone be by reviewing "a whole list of a sory impairment and if to even report abuse. The verified she had not do R1, or any other residents, an 11/5/20 to help ensure they buse. LSW-A voiced ACP (the psychology clinic) had the incident and made some for her ongoing care, including vers, but verified their action of R1's see from others. LSW-A stated to thing" the facility did to help to move her room to be closer in; however, acknowledged a per vulnerability would be of the ensure "certain things" to on the care plan including the scks. Further, LSW-A stated that" progress note (dated that" progress note (dated that some time with R1 in the stant personally see anything | F6                                 |   |                         |                            |                    |

|                          | OF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MUL<br>A. BUILD | TIPLE CONSTRUCTION  |                            | ` ´COM | E SURVEY<br>PLETED         |
|--------------------------|--|--|----------------------|---|----------------------------|--------|----------------------------|
|                          |  | 245438   | B. WING              |   |                            |        | C<br>18/2020               |
|                          | PROVIDER OR SUPPLIER   | AB CENTER  |                      | STREET ADDRESS, CITY, STATE, ZIP CODE  1717 UNIVERSITY DRIVE SOUTHEAST  SAINT CLOUD, MN 56304 |                            |        | 10/2020                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  |   | CTION SHOULD O THE APPROPE | BE     | (X5)<br>COMPLETION<br>DATE |
| F 600                    | NP-A described R2 often displayed poor health. NP-A recall 8/27/20, where a stroiced R2 was doing concerning behavior was notified on 10/1 laboratory draw an ordered clozapine; vacation at the time updated. NP-A stathave re-contacted received back as a abruptly could dempsychotic symptom been off his clozaphe was arrested. Nof R2's escalating I voiced had their clinave started other options available." antipsychotic medinave side effects wor desire and if the contribute to those R2 been medicated "helped him to make potentially not sexual A provided Vulnera Prevention policy, opurpose of providing residents which is policy outlined all repotential abuse and safe and remain frothe nursing home. | age 37 his nursing home admission. 2 as a "very poor historian" who or insight into his own mental ed seeing R2 in person on taff person was present and ng well overall and having no ors. NP-A stated their clinic 19/20, when R2 refused his d pharmacy would not fill his however, NP-A was on a so she was not personally ted the nursing home should them if no phone call was omeone stopping clozapine constrate a return of their is adding R2 appeared to have ine for "about 15 days" when in it is adding R2 appeared to have ine for "about 15 days" when in it is adding R2 appeared to have ine for "about 15 days" when in it is adding R2 appeared to have it is adding R2 appeare | F 6                  | 600   |                            |        |                            |

|                          | OF DEFICIENCIES OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MUL <sup>*</sup><br>A. BUILDI | TIPLE CONSTRUCTION  NG   |           | DATE SURVEY<br>COMPLETED   |
|--------------------------|---|--|------------------------------------|--|-----------|----------------------------|
|                          |   | 245438   | B. WING                            |  |           | C<br>11/18/2020            |
|                          | PROVIDER OR SUPPLIER  |  |                                    | STREET ADDRESS, CITY, STATE, ZIP CO<br>1717 UNIVERSITY DRIVE SOUTHEAS<br>SAINT CLOUD, MN 56304     | DDE       | 11/10/2020                 |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                | PROVIDER'S PLAN OF CORF<br>( (EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETION<br>DATE |
| F 600                    | would intervene in be likely to occur. The assessment, of residents with no might lead to confliresidents with a his and, " residents those that requires and/or are totally diseparate, "Procedu Abuse," was affixe be implemented shabuse happen. This the resident from the resident from the resident from the resident from the [IDT] should mare ident's plan of control of the IJ which begand on 11/18/20, when implemented a remomprehensively reabuse from others; at risk for abuse for potential abuse; and facility's abuse president and of 11/18/20, from 3:44 | situations where abuse would This included analysis and, care planning, and monitoring eeds and behaviors which ict or neglect, such as story of aggressive behaviors," with communication disorders, [sic] heavy nursing care ependent staff." In addition, a ures for an Allegation of Sexual d which outlined a procedure to nould an allegation of sexual s procedure included removing the accused, assessing them the ding them to the hospital for the procedure outlined, ctim) returns from the hospital, eet with resident and re-assess | F 6                                | 00   |           |                            |
|                          | training on abuse,<br>of potential abuse,<br>management and i<br>and treatments had   | including signs and symptoms along with behavioral resident refusal of medication dibeen completed.  t/Correct Alleged Violation   | F 6                                | 10   |           | 12/23/20                   |

|                          | OF DEFICIENCIES OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | l ` ′               | PLE CONSTRUCTION  G  | (X3) DATE SURVEY<br>COMPLETED |
|--------------------------|---|---|---------------------|--|-------------------------------|
|                          |   | 245438  | B. WING _           |  | 11/18/2020                    |
|                          | PROVIDER OR SUPPLIER  | AB CENTER   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304  | 11/10/2020                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)  | D BE COMPLÉTI                 |
| F 610                    |   | age 39 onse to allegations of abuse,  | F 61                | 0  |                               |
|                          | must:   | n, or mistreatment, the facility  |                     |  |                               |
|                          | violations are thoro  |   |                     |  |                               |
|                          |   | ent further potential abuse,<br>n, or mistreatment while the<br>progress.   |                     |  |                               |
|                          | designated represe<br>accordance with St<br>Survey Agency, wit<br>incident, and if the<br>appropriate correct<br>This REQUIREME | ort the results of all e administrator or his or her entative and to other officials in tate law, including to the State thin 5 working days of the alleged violation is verified cive action must be taken. NT is not met as evidenced |                     |  |                               |
|                          | facility failed to ens<br>reviewed who had<br>cared for in a mann<br>evidence and not p   | v and document review, the sure 1 of 1 residents (R1) been sexually assaulted was ner which would help preserve obtentially impede a criminal r sexual assault examination.   |                     | " R1 had a SANE assessment completed on 11/6/2020 and the incontinence product which had be removed from resident R1 was reand provided to the police.  " Residents who are victims of are at risk of being affected. Vulne  | trieved<br>a crime            |
|                          | Findings include:   |   |                     | assessments completed and four other resident who are currently v  | nd no                         |
|                          | dated 11/6/20, ider allegation of sexua another resident hat having sexual inter outlined the police alleged perpetrator        | agency (SA) Incident Report, ntified a facility' reported I abuse involving R1 when ad been found in R1's room " course" with her. The report were contacted and the (AP) was removed from the R1 was transported to the cion.          |                     | a crime.  " Nursing home staff educated importance of securing a crime so until police arrive.  " Weekly audits for 2 months for monitoring for residents who are of a crime to ensure the crime secure will be completed. If there residents who have been a victim | cene or victims ene is are no |

|                          | OF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MUL <sup>*</sup><br>A. BUILDI |    | E CONSTRUCTION  |       | E SURVEY<br>PLETED         |
|--------------------------|--|--|------------------------------------|----|---|-------|----------------------------|
|                          |  | 245438   | B. WING                            |    |   |       | C<br>18/2020               |
|                          | PROVIDER OR SUPPLIER   | B CENTER   |                                    | 1  | TREET ADDRESS, CITY, STATE, ZIP CODE 717 UNIVERSITY DRIVE SOUTHEAST 6AINT CLOUD, MN 56304   | 1 117 | 10/2020                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                | X  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY)  | BE    | (X5)<br>COMPLETION<br>DATE |
| F 610                    | R1's quarterly Minir 8/29/20, identified F depression, and has hort-term memory as having no speed never, able to unde Further, R1 require her activities of dail R1's progress note had left the facility fresident incident." home on the same R1's corresponding Community Care P R1 had been transpeing found, " in (NA)-A], being vagi Assailant was pinnitook 3 staff member patient reported and out of patient for section of the report Activity," identified I changed prior to he "peri-area cleaned when interviewed overified she was the sexually assaulted 11/5/20. NA-A state naked on top of R1 buttocks visibly goin peri-area. The male R1 and taken to his the nurse working in the section of the section of the report of the peri-area. The male R1 and taken to his the nurse working in the section of the section of the report of the section of the section of the report of the section o | mum Data Set (MDS), dated R1 had anxiety and d both long-term and impairment. R1 was recorded the ability and was rarely, or extand others verbally. d extensive assistance with y living (ADLs).  dated 11/6/20, identified R1 for evaluation "after resident to R1 returned to the nursing | F6                                 | 10 | crime, conduct staff interviews to v staff knowledge of securing a crime scene.  " Audit results to be reviewed at monthly QAPI to evaluate the effectiveness of audit continuation " NHA/Designee is responsible |       |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  |                     |   | (X3) DATE SURVEY COMPLETED C |                            |
|--|---|--|---------------------|---|------------------------------|----------------------------|
|  |   | 245438   | B. WING _           |   | l                            | /18/2020                   |
|  | PROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1717 UNIVERSITY DRIVE SOUTHEAST<br>SAINT CLOUD, MN 56304       |                              |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | ULD BE                       | (X5)<br>COMPLETION<br>DATE |
| F 610  | NA-A verified she to vagina and placed was sent to the hor  | then used a wipe to clean R1's<br>a new brief on her before she<br>spital; however, voiced she did   | F 61                | 0   |                              |                            |
|  | not recall any visib she cleaned her.  During interview or registered nurse (F with NA-A when the assaulted happeners asking NA-A to pladenied ever directibeing sent to the hexamination. RN-E to [her]" to save the when the assault he hospital called backwere able to retriev basket and send it | In 11/13/20, at 10:10 a.m. RN)-B stated she was working e incident of R1 being sexually ed on 11/5/20. RN-B recalled uce a new brief on R1; however, ng her to clean her prior to R1 ospital for a sexual assault a stated it "never even occurred e brief R1 had been wearing pappened. However, the k to the nursing home and they we the brief from the trash over to the hospital. |                     |   |                              |                            |
|  | (DON) was intervied sexually assaulted nursing home. The not have cleaned if it was not the facility in a way "to preser crime. Further, the planned to do som  | :32 a.m. the director of nursing ewed and verified R1 had been by another resident at the DON explained NA-A should R1 up following the incident as ty policy and staff need to act ve evidence" of a potential DON expressed they had e education with the staff on ter, it had not been completed  |                     |   |                              |                            |
|  | Prevention policy, attached procedure Allegation of Sexua series of steps to be made. This include  | able Adult Abuse and Neglect<br>dated 9/11/20, identified an<br>e titled, "Procedures for an<br>al Abuse," which directed a<br>be done after an allegation is<br>ed, "Do not shower or change<br>o not discard clothing or bed   |                     |   |                              |                            |

|                          | OF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` ′                |     | E CONSTRUCTION  | (X3) DATE SURVEY COMPLETED C |              |
|--------------------------|--|---|--------------------|-----|---|------------------------------|--------------|
|                          |  | 245438  | B. WING            |     |   |                              | :<br>18/2020 |
|                          | PROVIDER OR SUPPLIER   | B CENTER  |                    | 17  | REET ADDRESS, CITY, STATE, ZIP CODE  17 UNIVERSITY DRIVE SOUTHEAST  AINT CLOUD, MN 56304  | <u> </u>                     | 10/2020      |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD I<br>CROSS-REFERENCED TO THE APPROPR<br>DEFICIENCY)   | (X5)<br>COMPLETION<br>DATE   |              |
| F 610                    | linen Preserve be<br>for possible crime s  | ge 42<br>oth parties clothing and linen<br>cene." The policy lacked any<br>on on the use of wipes on an   | F 6                | 610 |   |                              |              |
|                          | CFR(s): 483.30(a)( §483.30 Physician 3 A physician must per recommendation the a facility. Each resistant assistant, nurse prespecialist must provimmediate care and §483.30(a) Physician The facility must en §483.30(a)(1) The resistant assistant and subsequently has a physician is unavail. This REQUIREMENT by:  Based on interview facility failed to coor physician orders and psychiatric physician health needs were a (R2) reviewed who and subsequently has a physician subsequently has a physician and subsequently has a physici | Services ersonally approve in writing a at an individual be admitted to dent must remain under the A physician, physician actitioner, or clinical nurse vide orders for the resident's d needs.  an Supervision. sure that- medical care of each resident ohysician; her physician supervises the idents when their attending | F 7                | 710 | " R2 was discharged from the fact 11/6/2020. " Residents who refuse their psychotropic medications, treatmen labs have the potential to be affecte their physician is not notified of the refusals. Residents with psychotrop medications will be monitored daily | ts, or<br>d if<br>ic         | 12/23/20     |
|                          | Findings include:  |   |                    |     | business days for any refusals of<br>psychotropic medications, treatmen<br>labs. If patterns of refusals occur, the   |                              |              |

|                          | OF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                 | TIPLE CONSTRUCTION   | СОМ  | E SURVEY<br>PLETED         |
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|                          |  | 245438   | B. WING             |  |  | C<br><b>18/2020</b>        |
|                          | PROVIDER OR SUPPLIE  |  |                     | STREET ADDRESS, CITY, STATE, Z<br>1717 UNIVERSITY DRIVE SOUTH<br>SAINT CLOUD, MN 56304   | IP CODE  | 10.2020                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC   | ION SHOULD BE<br>THE APPROPRIATE   | (X5)<br>COMPLETION<br>DATE |
| F 710                    | R2's quarterly MD had schizophrenia person's ability to and moderate coordemonstrated no rejection of care is supervision with his room.  R2's care plan, do communication do "Anticipate and midentified to consumedication related listed several integoal including, but the medication (s) pharmacist and preductions, and meffects including at R2's medical recovere reviewed and threw The note outlined [sic] medication so The note identified medication so The note identified medication and direfused and threw The note identified medication so The note identified medication and the results of the roote identified medication and the results of the roote identified medication and the results of the roote identified medication and the roote identifie | page 43 a) (a disorder which affects a think, feel, and behave clearly) gnitive impairment. Further, R2 hallucinations, delusions or behaviors, and required only ambulation in the corridor and ated 10/5/20, identified R2 had a eficit and directed staff to, eet needs." Further, R2 was ame antipsychotic medication of being free of psychotropic d complications. The care plan rventions to help R2 meet this t not limited to, administering as ordered, consulting with the hysician on potential dose nonitoring for adverse side agitation and restlessness.  and, including progress notes, and identified the following:  and office at the employee.  The progress note identified the order R2's antipsychotic raw routine laboratory work. R2 whis coffee at the employee.  The progress note identified the order of the progress note identified the delivery ince resident refused lab draw."  The draw of the progress note refused the laboratory draw on the days later), a progress note refused the laboratory draw on the days later), a progress note refused the laboratory draw on the days later), a progress note refused the laboratory draw on the days later), a progress note refused the laboratory draw on the days later), a progress note refused the laboratory draw on the progress of the laboratory draw on the days later), a progress note refused the laboratory draw on the lab(s) are progressition could be filled. | F 7                 | physician will be notified Licensed nursing sta on the importance of ider and notifying the physicia Weekly audits for 2 r residents with psychotror for a pattern of refusals of psychotropic medications labs will be completed to physician has been notifit Audit results to be re monthly QAPI to evaluate effectiveness of audit cor DON/Designee is res | ff/TMA educated ntifying refusals an of the refusals. months for bic medications of the s, treatments or validate that the ed of the refusal. viewed at e the ntinuation |                            |

|                          | T OF DEFICIENCIES<br>DF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′       | IPLE CONSTRUCTION IG  | COMPLETED |                            |
|--------------------------|--|--|-----------|---|-----------|----------------------------|
|                          |  | 245438   | B. WING _ |   | 11        | C<br>/ <b>18/2020</b>      |
|                          | PROVIDER OR SUPPLIER   |  |           | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1717 UNIVERSITY DRIVE SOUTHEAST<br>SAINT CLOUD, MN 56304         |           | 710/2020                   |
| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   |  |           | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | JLD BE    | (X5)<br>COMPLETION<br>DATE |
| F 710                    | corresponding Ger Progress Note, dar medical nurse praction R2's refusal to a 10/19/20, so no madministration as a consuming 500 mg note outlined NP-E tell [nursing home] psychiatrist is the consuming 500 mg note outlined NP-E tell [nursing home] psychiatrist is the consuming 100 mg 10/23/20, a laterecorded which idea on R2's refusal to a clozapine. The note nystrom appointme possible]. Nystrom made for 11/12/20 On 10/31/20, a progressible in the laterest was a looked anythin began yelling at writing around, included anything around anything hallucinatio at him and resident you' drew his around in the manufacture of the progression of the progressio | nevive (Physician Group) ted 10/22/20, identified R2's ctitioner (NP)-B was updated allow the laboratory draw on edication was available for a result. R2 was listed as g of clozapine everyday. The B responded, "Please call and to keep trying with labs. His ordering provider I believe."  De-entry progress note was entified NP-B had been updated allow laboratory draw(s) for his e continued, "NP[-B] wanted ent made ASAP [as soon as [psychiatry clinic] appointment ."  Orgress note identified R2 came est Desk.' R2 was questioned if g by the staff, but then " citer to shut up. After a few me down the hallway and he eyelled 'you fucking nigger' X3 was recorded as spending "a e day outside of his room cluding standing by the front couttons in attempt to open it. The evidence of interventions taff to calm or redirect R2 | F 71      |   |           |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   |  | (X2) MULTIPLE CONSTRUCTION A. BUILDING |     |   | (X3) DATE SURVEY COMPLETED |                            |
|--|---|--|--|-----|---|----------------------------|----------------------------|
|  |   | 245420   |  |     |   |                            | 0                          |
|  |   | 245438   | B. WING                                |     |   | <u>  11/</u>               | 18/2020                    |
|  | PROVIDER OR SUPPLIER NURSING AND REHA   | B CENTER   |  | 1   | TREET ADDRESS, CITY, STATE, ZIP CODE 717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304                         |                            |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG                      |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPI<br>DEFICIENCY) | BE                         | (X5)<br>COMPLETION<br>DATE |
| F 710  | is very abnormal be nurse sat down nex which was effective note identified the ladraw R2's lab(s) on what caused reside provided education draw, however, the be observed as resaggression or agita approached nurses. Nurse asked what tresident replied 'Th hates me, and that identified the nurse proceeded to hug thand start crying. Gowas contacted due restlessness and at twice a day as-need (3) day period " offectiveness." R2' Phone Encounter nursing home has receiving R2 " is agitation, aggression was receiving Clozanot been sent as the completed, thou labs staff are connote identified an otwice a day as-need provided along with follow-up with patie provider] this week | chavior for resident." The cut to R2 and talked with him in calming him down. The aboratory had attempted to the prior shift which " is unt to become upset." R2 was on the importance of the lab note outlined R2 continued to tless but without physical tion. The note continued, "[R2] stating 'I am hearing voices.' the voices were telling him and at no one likes me, everyone I should just die." The note provided comfort to R2 whom he nurse and become upset enevive (physician service) to R2's continued order for clonazepam 0.5 mg ded was provided for a three until cozapine issue was administered to R2 and the | F                                      | 710 |   |                            |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING   |                     |  | (X3) DATE SURVEY COMPLETED C |                            |
|--|--|---|---------------------|--|------------------------------|----------------------------|
|  |  | 245438  | B. WING _           |  |                              | /18/2020                   |
|  | PROVIDER OR SUPPLIER   |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1717 UNIVERSITY DRIVE SOUTHEAST<br>SAINT CLOUD, MN 56304          |                              |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE                        | (X5)<br>COMPLETION<br>DATE |
| F 710  | which identified R2 around facility thro shift] report, reside did not sleep. Resicigarettes for him. want! I'm over 18! reassurance provious staff member at frostaff member when threw desk supplies outlined education provided, however more angry as staff provided time and and " appeared refuse medications.  On 11/2/20, a progentered R2's room and was laying in the R2 proceeded to approvided R2 his or his right hand arout then took his hand. The note identified appropriate to grate left the room.  On 11/2/20, a subsidentified, "New be Behavior addresse.  On 11/3/20, identified (G)-A and the nursilaboratory draw contact the sidentified (G)-A and the nursilaboratory draw contact | was " noted to be pacing ugh out the morning. Per [night ent was up all night pacing and ident asking staff to purchase Yelling at staff 'I can smoke if I Emotional support and ded. Resident then approached ont desk. Became upset with a unable to get cigarettes and es across lobby." The note and encouragement was R2 " Becomes more and ff re-approach." R2 was then space to express his feelings to calm down but continues to | F 71                | 0  |                              |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION A. BUILDING  |                     |  | (X3) DATE SURVEY<br>COMPLETED |                            |
|--|--|---|---------------------|--|-------------------------------|----------------------------|
|  |  | 245438  | B. WING _           |  |                               | C<br>/ <b>18/2020</b>      |
|  | PROVIDER OR SUPPLIER   |   |                     | STREET ADDRESS, CITY, STATE, ZIP O<br>1717 UNIVERSITY DRIVE SOUTHEA<br>SAINT CLOUD, MN 56304 | CODE                          |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY)  | I SHOULD BE                   | (X5)<br>COMPLETION<br>DATE |
| F 710  | picked up an orange his guardian." NP-continued inability R2 " had been of weeks, and that we to be sent in to the R2 was sent to the R2 was sent to the R2's corresponding dated 11/3/20, ider R2 had gone without wo weeks as he were draws. The note ider [due to] not getting present, and typical labs drawn, so the seeking an order fraddendum was did "I [NP-B] don't man orders this Upon nurses stated that needed, now need threw a traffic constates that she has and aggressive as ED. Facility staff a behaviors at this tiprovided to send FR2's ED Provider IR2 presented to the listed as, "Aggress was homeless before the nursing home, throwing a telephotogical was unatter ED, but did end | It taking any labs', then resident ge traffic cone and threw it at B was updated regarding the to draw the needed lab(s) and off his clozapine for almost two riter believed resident needed hospital for further evaluation." It hospital ER via ambulance. It generally | F 71                |  |                               |                            |
|  |  | onsultation was completed and   |                     |  |                               |                            |

| AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER: |  | A. BUILDING   |                     |  | COMPLETED |                            |
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|   |  | 245438  | B. WING             |  | 1         | C<br>1/18/2020             |
|   | PROVIDER OR SUPPLIER   | AB CENTER   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304      |           | 1710/2020                  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC ( (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE    | (X5)<br>COMPLETION<br>DATE |
| F 710   | cleared him for dischome. R2 was record to go back on his in Behavioral Access identified R2 report as they made him the would return to on my best behavioral R2 denied command himself or others, the hallucinations at timestatus was listed wand aggressive belowed was cleared to returned from the Eincluding a urinally singuity for a blade medication or treat The note conclude practitioner] in 2 days identified the pharm completed laborate his Clozapine [sic] possible." The phacontact the hospital results and would conote concluded, "With pharmacy." Further 11/4/20, identified to | charge back to the nursing brided as, " he is now willing predications." Further, R2's progress note, dated 11/3/20, and the nursing his medications feel "stressed out." R2 voiced the nursing home and " be or and I'll take my medicine." In hallucinations to hurt but acknowledged having visual hies. Further, R2's clinical hich identified highly impulsive havior(s) towards others. R2 arn to the nursing home.  Tess note identified R2 and had several labs, his completed. The results were der infection and no new ment orders were provided. d, "He is to see [nurse] | F 7                 | 10   |           |                            |
|   | been without his cle<br>home expressed h<br>last administration  | n how many days R2 had<br>ozapine; which the nursing<br>ad been "two weeks since his<br>" The pharmacist then<br>eded to speak with the provider  |                     |  |           |                            |

| NAME OF PROVIDER OR SUPPLIER  TALAHI NURSING AND REHAB CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE   | C<br>18/2020               |
|--|----------------------------|
| NAME OF PROVIDER OR SUPPLIER  TALAHI NURSING AND REHAB CENTER   (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  STREET ADDRESS, CITY, STATE, ZIP CODE  1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304   PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE   |                            |
| PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE   |                            |
| DEFICIENCY)  | (X5)<br>COMPLETION<br>DATE |
| F 710  Continued From page 49  who prescribed the medication to see if it needed to be re-titrated given the length of time R2 had been off the medication. The pharmacist voiced a message had been left for the provider, and the note concluded, "Writer is awaiting a respond fro pharmacist"  On 11/6/20, at 1:38 a.m. a progress note identified R2 sexually assaulted a female resident and was removed from the facility by the police.  R2's Medication Administration Record (MAR), dated 10/20/20 to 11/20/20, identified R2's physician ordered medications and their subsequent administration record(s). An order was listed for clozapine 500 milligrams (mg) everyday; which had a listed start date of 6/25/20. The medication was record as being given and consumed by R2 until 10/20/20. From 10/21/20 to 11/5/20, the MAR identified nearly all subsequent doses of the medication were not given with numerous entries of, "18," which was identified via legend as, "Med not available from pharmacy."  R2's medical record was reviewed and lacked evidence R2 escalating behaviors were communicated to R2's psychiatry team for new physician orders or direction despite him refusing the laboratory draw and subsequently having his prescribed antipsychotic medication held since 10/20/20.  On 11/13/20, at 1:07 p.m. registered nurse manager (RN)-A and licensed social worker (LSW)-A were interviewed. R2 admitted to the nursing home after a hospitalization and planned to discharge to a venue of less care when able to. |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION A. BUILDING   |                    |  | (X3) DATE SURVEY<br>COMPLETED |                            |
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|  |  | 045400   |                    |  |                               | С                          |
|  |  | 245438   | B. WING            |  |                               | /18/2020                   |
|  | PROVIDER OR SUPPLIEI  NURSING AND REH  |  |                    | STREET ADDRESS, CITY, STATE, ZIP CO<br>1717 UNIVERSITY DRIVE SOUTHEAS<br>SAINT CLOUD, MN 56304 |                               |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |  | SHOULD BE                     | (X5)<br>COMPLETION<br>DATE |
| F 710  | never really identite to the weeks lead female resident of admitted using classification and consistently the secondary of the prescription. RN-Acontacted R2's nuclear contacted R2's nuclear contacted R2's nuclear composition of the clossing about the clossing and the time, shimmediate dange.  On 11/13/20, at 3 practitioner (NP)-I someone who was prior to 10/19/20, aware of any behavior to 10/19/20, a | fied him to have behaviors prior ing up to the incident involving a n 11/5/20. RN-A explained R2 ozapine for his schizophrenia ook the medication until e refused the routine laboratory e pharmacist would not fill the A explained the cart nurse then urse practitioner (NP)-B a couple 22/20) who voiced she did not starting new medication or capine and directed an R2's psychiatry team should be as possible. RN-A stated she contact the psychiatric team via iter, was unable to reach anyone sage. A return call was never and RN-A verified she never o contact the psychiatry provider ite "didn't feel anybody was in | F 7                | '10  |                               |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION A. BUILDING   |                     |  | (X3) DATE SURVEY<br>COMPLETED |                            |
|--|---|--|---------------------|--|-------------------------------|----------------------------|
|  |   | 245438   | B. WING _           |  |                               | C<br>/ <b>18/2020</b>      |
|  | PROVIDER OR SUPPLIEF  |  |                     | STREET ADDRESS, CITY, STATE, ZIP 1717 UNIVERSITY DRIVE SOUTHE SAINT CLOUD, MN 56304        | CODE                          |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTIOI<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | N SHOULD BE<br>E APPROPRIATE  | (X5)<br>COMPLETION<br>DATE |
| F 710  | provider service widays later on 10/2 medication orders the nursing home R2's psychiatry teridea" what they or NP-B stated they behaviors seemed time, a three (3) dimedication used from 11/3/20, NP-B was now being veritwo weeks" witho NP-B stated this widad not had his chordered him to be nursing home felt anymore. The ED laboratory draw(s) nursing home was clozapine restarter facility on 11/4/20 aware R2's psychinotified of his refurdraw(s) and subservoicing that was "to When interviewed director of nursing heard about R2 no clozapine when stand a nurse report medication to give date she was first his prescribed closes was not told usexual assault of the DON voiced in the poon woiced in the poon was stated the poon woiced in the poon woice woice woice woice woiced in the poon woice woice woice woice woiced in the poon woice woice woice woice woiced in the poon woice woiced in the poon woice woiced in the poon woiced in the poon woiced in the poon woice woiced in the poon woiced in the | ras notified about it a couple 2/20. NP-B voiced no new were given as she assumed had already been in touch with am and she would have "no dered or did. On 10/31/20, were again notified R2's to be worsening and, at that ay dose of clonazepam (a or anxiety) was provided. Then was updated again and told R2 ry aggressive and had gone for ut his antipsychotic medication. Was the first time she realized he ozapine "for awhile" and then evaluated in the ED as the they couldn't control him completed the necessary and, to her knowledge, the working on getting his d when he returned to the NP-B expressed she was not fatry team had never been sal to allow the laboratory equent holding of his clozapine | F 71                |  |                               |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING   |                     |  | (X3) DATE SURVEY<br>COMPLETED   |    |                            |
|---|---|---|---------------------|--|---|----|----------------------------|
|   |   | 245438  | B. WING             |  |   |    | C<br>18/2020               |
|   | PROVIDER OR SUPPLIER  |   |                     | STREET ADDRESS, CIT<br>1717 UNIVERSITY DE<br>SAINT CLOUD, MN | RIVE SOUTHEAST  |    | 10/2020                    |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | (EACH CORR   | R'S PLAN OF CORRECTION<br>ECTIVE ACTION SHOULD<br>ENCED TO THE APPROPI<br>DEFICIENCY) | BE | (X5)<br>COMPLETION<br>DATE |
| F 710   | refused the laboral had his medication.  During the abbrevi 11/18/20, multiple interview NP-A regincident which hap was found in R1's missed return call a message was lefinterview would no 12/2/20, at 1:41 p.1 verified she helped for the duration of NP-A described R2 often displayed pohealth. NP-A state 10/19/20, when R2 and pharmacy wou clozapine; howeve time so she was no stated the nursing re-contacted them back as someone could demonstrate symptoms adding his clozapine for "a arrested. NP-A state scalating behavious had their clinic bees started other medicavailable."  A provided Physici 3/27/20, identified under the care of a the nursing home. resident's attending resident's attending the sident's attending the care of a the nursing home. | tory draw and subsequently in not provided.  ated survey, from 11/13/20 to phone calls were attempted to parding R2's behavior and the pened on 11/5/20, where R2 room sexually assaulting her. A was provided on 11/18/20, and it indicating a telephone to be possible until 12/2/20. On m. NP-A was interviewed and I oversee his psychiatric care his nursing home admission. 2 as a "very poor historian" who for insight into his own mental did their clinic was notified on a refused his laboratory draw ald not fill his ordered r, NP-A was on vacation at the ot personally updated. NP-A | F 7                 | 10   |   |    |                            |

| AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | l ` ′               | TIPLE CONSTRUCTION  NG   | COMPLETED                                       |                            |
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|  |   | 245438  | B. WING             |  |   | C<br>18/2020               |
|  | PROVIDER OR SUPPLIER  NURSING AND REHA  | B CENTER  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1717 UNIVERSITY DRIVE SOUTHEAST<br>SAINT CLOUD, MN 56304  | ,   |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFI)<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICIENCY)   | D BE  | (X5)<br>COMPLETION<br>DATE |
| F 710  | desired. The policy guidance on coordi outside providers w  | ge 53 the nurse practitioners, as lacked any direction or nation of physician care with then the attending staff are needed therapies or  | F 7                 | 10   |   |                            |
| F 740<br>SS=G  | S483.40 Behaviora Each resident must provide the necess services to attain of practicable physical well-being, in according assessment and plencompasses a resident well-being, limited to, the preveand substance use This REQUIREMED by:  Based on interview facility failed to ensappropriately assessimplemented to ensof adverse events freviewed who demonstrates and substance use the substance of adverse events freviewed who demonstrates are substance. | I health services. It receive and the facility must ary behavioral health care and maintain the highest. I, mental, and psychosocial dance with the comprehensive an of care. Behavioral health sident's whole emotional and which includes, but is not ention and treatment of mental disorders.  No is not met as evidenced and document review, the ure escalating behaviors were seed and interventions sure safety and reduce the risk for 1 of 1 residents (R2) constrated increased physical | F 7                 | <ul> <li>" R2 was discharged from the factorisms.</li> <li>" Residents who refuse their psychotropic medications, treatmed labs and have noted increase or control in behaviors have the potential to the second sec</li></ul> | ents, or<br>hange                               | 12/23/20                   |
|  | stopping their antip<br>resulted in actual p<br>the lack of assessn<br>contributed to esca  | lucinations after abruptly sychotic medication. This sychosocial harm for R2 when nent and interventions lating behaviors and the nother resident resulting in  |                     | affected if new interventions and monitoring is not put into place. Rewith psychotropic medications will monitored daily on business days refusals of psychotropic medication treatments, or labs and for any incorreduced or changes in behavior. If patterns refusal and behaviors occur, the tereview and ensure interventions a monitoring are put into place.   | be<br>for any<br>ns,<br>rease<br>of<br>eam will |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  |                     |     | (X3) DATE SURVEY<br>COMPLETED  |                        |                            |
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|  |  |  | , N. BOILD          |     |  | (                      |                            |
|  |  | 245438   | B. WING             |     |  |                        | 18/2020                    |
| NAME OF  | PROVIDER OR SUPPLIE  | २  |                     | STF | REET ADDRESS, CITY, STATE, ZIP CODE  |                        |                            |
| TAL ALI  | NUDCING AND DELL   | AD CENTED  |                     | 171 | 7 UNIVERSITY DRIVE SOUTHEAST   |                        |                            |
| IALAHI   | NURSING AND REH  | AB CENTER  |                     | SA  | INT CLOUD, MN 56304  |                        |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY)  | BE                     | (X5)<br>COMPLETION<br>DATE |
| F 740  | A submitted state dated 11/6/20, ide allegation of sexu assaulting anothe R2 had been four having sexual interpretate the police were controlled to the police were controlled the police with the police were the police with the demonstrate weeks prior to his discharge from the police were policed the event him sexually assawas aware R2 has is room on 11/2/facility had contact a different room a witnessed standing resident's room and the police were policed to the police were policed to the policed the event him sexually assawas aware R2 has his room on 11/2/facility had contact a different room a witnessed standing resident's room and the policed the po | agency (SA) Incident Report, entified a facility' reported all abuse involving R2 sexually resident. The report outlined of in the resident's room " ercourse." The report outlined ontacted and removed R2 from r, the report listed several allegation which included nursing NA-B, licensed practical nurse stered nurse (RN)-B.  2:22 p.m. R2's appointed as interviewed. G-A stated she d in R2's care for over the past of R2 admitted to the nursing point of for some rehabilitation spitalization. G-A described in Stable until he went off his ed she felt he was doing "quite point of the second of the sec | F 7                 |     | "Licensed nursing staff and Soc Worker educated on the importance identifying refusals, monitoring for changes or increased behaviors, as putting interventions/monitoring in putting interventions/monitoring in putting interventions/monitoring in putting interventions for 2 months for residents with psychotropic medications, treatments or labs will completed to validate that the interventions and monitoring are in "Audit results to be reviewed at monthly QAPI to evaluate the effectiveness of audit continuation "DON/Designee is responsible" | e of ond olace.  tions |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING   |                     |   | TE SURVEY<br>MPLETED<br>C |                            |
|--|--|---|---------------------|---|---------------------------|----------------------------|
|  |  | 245438  | B. WING _           |   | 11                        | /18/2020                   |
|  | PROVIDER OR SUPPLIER   |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304             |                           | . 10:2020                  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | ULD BE                    | (X5)<br>COMPLETION<br>DATE |
| F 740  | the documentation had just been expression was not notifical laboratory draw, not his antipsychotic in frustrating to her a have contacted herospitalized or treat assaulting someor currently locked in pending against his which made her upescalation of R2's sexual assault on been prevented if appropriately. G-A have been prevented if appropriately. G-A have been prevented if appropriately and moderate cog demonstrated no have been prevented in and moderate cog demonstrated no have been prevented in an and moderate cog demonstrated no have been prevented in an and moderate cog demonstrated no have been prevented in an and moderate cog demonstrated no have been prevented in an and moderate cog demonstrated no have been prevented in an and moderate cog demonstrated no have been prevented in an | to her of him doing that as it ressed verbally to her by a staff of e could not recall. G-A stated and timely of R2 refusing the for the subsequent holding of medications, which was so the nursing home should are and he could have been ated sooner before sexually the. Further, G-A stated R2 was jail with multiple charges in from the sexual assault to set as she believed the entire behaviors and subsequent another resident could have the facility had responded reiterated, "I believe this could | F 74                |   |                           |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X2) MULT<br>A. BUILDIN  | PLE CONSTRUCTION  IG | (X3) DATE SURVEY COMPLETED C   |       |                            |
|---|---|--|----------------------|--|-------|----------------------------|
|   |   | 245438   | B. WING _            |  |       | /18/2020                   |
|   | PROVIDER OR SUPPLIER  |  |                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1717 UNIVERSITY DRIVE SOUTHEAST<br>SAINT CLOUD, MN 56304          | ,     |                            |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE | (X5)<br>COMPLETION<br>DATE |
| F 740   |   | age 56<br>e with the staff's ability to give   | F 74                 | 0  |       |                            |
|   | care?" This was ar  | nswered, "No." Further, the<br>ried R2's behaviors and   |                      |  |       |                            |
|   | communication del<br>"Anticipate and me<br>antipsychotic medi                         | ed 10/5/20, identified R2 had a ficit and directed staff to, et needs." R2 consumed cation and the care plan listed of psychotropic medication |                      |  |       |                            |
|   | related complication help R2 meet this good to, administering the consulting with the | ns with several interventions to<br>goal including, but not limited<br>ne medication(s) as ordered,<br>pharmacist and physician on             |                      |  |       |                            |
|   | adverse side effect<br>restlessness. Furth<br>was considered a v                      | uctions, and monitoring for<br>its including agitation and<br>her, the care plan identified R2<br>vulnerable adult due to his                  |                      |  |       |                            |
|   | interventions which<br>behavioral issues v<br>(IDT), evaluating for                   | ents and outlined several included discussing with the interdisciplinary team or possible causative factors if d, and, "Resident requires      |                      |  |       |                            |
|   | close observation."   | ' The care plan lacked further<br>2 would be closely observed to   |                      |  |       |                            |
|   |   | d, including progress notes, identified the following:   |                      |  |       |                            |
|   | ordered loxapine w<br>(mg) due to an abr  | ress note identified R2's vas reduced to 25 milligrams normal ECG. There were with the psychiatric nurse in one month.                         |                      |  |       |                            |
|   | refused his bath de   | ress note identified R2 had espite reproach. The note did er demonstrated behaviors by   |                      |  |       |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  |                     |   | (X3) DATE SURVEY<br>COMPLETED |                            |  |
|--|---|--|---------------------|---|-------------------------------|----------------------------|--|
|  |   | 245438   | B. WING _           |   | 11                            | C<br>/ <b>18/2020</b>      |  |
|  | PROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1717 UNIVERSITY DRIVE SOUTHEAST<br>SAINT CLOUD, MN 56304       |                               | , 10, 2020                 |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPI<br>DEFICIENCY) | OULD BE                       | (X5)<br>COMPLETION<br>DATE |  |
| F 740  | R2 despite refusion On 10/15/20, a FO recorded which list for review. R2 was schizophrenia and 8/18/20) was ident cognitive impairme "Mood/Behavior," is and restlessness. further information including how often happening, if at all demonstrated epistidentified a section interventions," white [medical doctor] which wobserved, trauma and monitoring, prexpression of feelito On 10/19/20, a propharmacy came to medication and drarefused and threw The note outlined, [sic] medication sin The note identified updated.  On 10/22/20 (three identified R2 had reproach R2 are | CUS progress note was ted, "Behaviors," as the reason recorded as having R2's loxapine reduction (from ified. R2 had moderate ant and a section labeled, dentified R2 as having anxiety However, the note lacked any on these listed behaviors, in the behaviors were, or specifics around any codes of them. Further, the note a labeled, "Care plan ch directed, "Notify MD ith any mood changes are informed approach observing ovide opportunities for | F 74                | 40  |                               |                            |  |
|  | 10/22/20, identified  | Genevive Progress Note, dated<br>d R2's medical nurse<br>d was updated on R2's refusal   |                     |   |                               |                            |  |

|                          | OF DEFICIENCIES OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                 | IPLE CONSTRUCTION  NG   | COMPLETED |                            |
|--------------------------|---|--|---------------------|---|-----------|----------------------------|
|                          |   | 245438   | B. WING _           |   | 1,        | C<br>I/ <b>18/2020</b>     |
|                          | PROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1717 UNIVERSITY DRIVE SOUTHEAST<br>SAINT CLOUD, MN 56304       |           | 110/2020                   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPF<br>DEFICIENCY) | ULD BE    | (X5)<br>COMPLETION<br>DATE |
| F 740                    | medication was aversult. R2 was listed clozapine everyday responded, "Please keep trying with late ordering provider I.  On 10/23/20, a late recorded which ide on R2's refusal to a clozapine. The notenystrom appointment possible]. Nystrom made for 11/12/20.  On 10/31/20, a progand sat by the 'We he needed anything began yelling at with minutes a [NA] car looked at her and yelling around, incompared to the walking around, incompared by the septite these behalf on 11/1/20, a progrecorded as being, having hallucination at him and residen you' drew his arrigoing to punch nur is very abnormal benurse sat down near the septiment of the septiment | cory draw on 10/19/20, so no ailable for administration as a act as consuming 500 mg of a. The note outlined NP-B e call and tell [nursing home] to be. His psychiatrist is the believe."  e-entry progress note was entified NP-B had been updated allow laboratory draw(s) for his e continued, "NP[-B] wanted ent made ASAP [as soon as [psychiatry clinic] appointment."  gress note identified R2 came st Desk.' R2 was questioned if g by the staff, but then " iter to shut up. After a few me down the hallway and he yelled 'you fucking nigger' X3 was recorded as spending "a e day outside of his room cluding standing by the front outtons in attempt to open it. my evidence of interventions taff to calm or redirect R2 | F 74                | 10  |           |                            |

|                          |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING |     |  | (X3) DATE SURVEY<br>COMPLETED |                            |
|--------------------------|--|--|--|-----|--|-------------------------------|----------------------------|
|                          |  |  |  |     |  |                               | 0                          |
|                          |  | 245438   | B. WING                                |     |  | 11/                           | 18/2020                    |
|                          | PROVIDER OR SUPPLIER  NURSING AND REHA   | B CENTER   |  | 1   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1717 UNIVERSITY DRIVE SOUTHEAST<br>SAINT CLOUD, MN 56304        |                               |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG                      |     | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE                            | (X5)<br>COMPLETION<br>DATE |
| F 740                    | note identified the ladraw R2's lab(s) on what caused reside provided education draw, however, the be observed as resaggression or agita approached nurses. Nurse asked what tresident replied 'The hates me, and that identified the nurse proceeded to hug thand start crying. Gawas contacted due restlessness and an twice a day as-need (3) day period " uresolved." This was note recorded, " effectiveness."  R2's corresponding note, dated 10/31/2 had contacted the sexperiencing increal hallucinations pa [sic], though a scrip are waiting for lab very patient continues to concerned for his a an order for clonazed as-needed for three with, "Nursing staff PCP [primary care his agitation." | aboratory had attempted to the prior shift which " is ent to become upset." R2 was on the importance of the lab note outlined R2 continued to tless but without physical tion. The note continued, "[R2] stating 'I am hearing voices.' the voices were telling him and at no one likes me, everyone I should just die." The note provided comfort to R2 whom he nurse and become upset enevive (physician service) to R2's continued order for clonazepam 0.5 mg ded was provided for a three until cozapine issue was administered to R2 and the | F                                      | 740 |  |                               |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTI<br>A. BUILDIN   | PLE CONSTRUCTION  G | COM  | (X3) DATE SURVEY COMPLETED C |                            |  |
|--|---|--|---------------------|--|------------------------------|----------------------------|--|
|  |   | 245438   | B. WING _           |  |                              | /18/2020                   |  |
|  | PROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP O<br>1717 UNIVERSITY DRIVE SOUTHEA<br>SAINT CLOUD, MN 56304 | CODE                         |                            |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COI<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY)  | I SHOULD BE                  | (X5)<br>COMPLETION<br>DATE |  |
| F 740  | shift] report, resided did not sleep. Resicigarettes for him. want! I'm over 18!' reassurance provistaff member at frostaff member whe threw desk supplicioutlined education provided, however more angry as starprovided time and and " appeared refuse medications.  On 11/2/20, a progentered R2's room and was laying in R2 proceeded to provided R2 his or his right hand arouthen took his hand. The note identified appropriate to gralleft the room.  On 11/2/20, a subsidentified, "New be Behavior addresse.  On 11/3/20, a progwere received from emergency room (11/3/20, identified (G)-A and the nursilaboratory draw copresent. The note | ugh out the morning. Per [night ent was up all night pacing and ident asking staff to purchase Yelling at staff 'I can smoke if I Emotional support and ded. Resident then approached ont desk. Became upset with a unable to get cigarettes and es across lobby." The note and encouragement was ", R2" Becomes more and ff re-approach." R2 was then space to express his feelings to calm down but continues to | F 74                |  |                              |                            |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING   |                     |  | (X3) DATE SURVEY<br>COMPLETED |                            |  |
|--|--|---|---------------------|--|-------------------------------|----------------------------|--|
|  |  | 245438  | B. WING _           |  | 11                            | C<br>/ <b>18/2020</b>      |  |
|  | PROVIDER OR SUPPLIEF   |   |                     | STREET ADDRESS, CITY, STATE, ZIP COD<br>1717 UNIVERSITY DRIVE SOUTHEAST<br>SAINT CLOUD, MN 56304     | E                             | 110/2020                   |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE API<br>DEFICIENCY) | OULD BE                       | (X5)<br>COMPLETION<br>DATE |  |
| F 740  | picked up an oran his guardian." NP-continued inability R2 " had been of weeks, and that weeks as he weeks and typic labs drawn, so the seeking an order faddendum was dir I [NP-B] don't ma orders this Uponurses stated that needed, now need threw a traffic constates that she ha and aggressive as ED. Facility staff a behaviors at this tiprovided to send for the seeks weeks as the weeks as he weeks as the weeks as he we he we he we he weeks as h | ge traffic cone and threw it at B was updated regarding the to draw the needed lab(s) and off his clozapine for almost two riter believed resident needed hospital for further evaluation." It hospital ER via ambulance.  g Genevive Progress Note, ntified NP-B was contacted as put his ordered clozapine for was refusing to allow laboratory dentified, "Behaviors increased g med." R2's guardian was ally was able to get R2 to have a nursing home staff were for the needed lab draw(s). An extated by NP-B which identified, nage this, his psych provider in calling site nurse back, site orders for labs no longer at okay to send to ED [R2] at his guardian. Guardian is never seen [R2] as agitated to he is right now, wants sent into also aren't able to manage me." A telephone order was | F 74                |  |                               |                            |  |

|                          | FOF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MUL <sup>*</sup><br>A. BUILDI | TIPLE CONSTRUCTION ING   |        |          | E SURVEY<br>PLETED         |
|--------------------------|--|---|------------------------------------|--|--------|----------|----------------------------|
|                          |  | 245438  | B. WING                            |  |        |          | C<br>18/2020               |
|                          | PROVIDER OR SUPPLIER   | B CENTER  |                                    | STREET ADDRESS, CITY, STATE, ZIP CO<br>1717 UNIVERSITY DRIVE SOUTHEAS<br>SAINT CLOUD, MN 56304 |        | <u> </u> | 10/2020                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                |  | SHOULD | BE       | (X5)<br>COMPLETION<br>DATE |
| F 740                    | was completed and back to the nursing he is now willing medications." Furth progress note, date reported not taking him feel "stressed or taking him feel "st | I cleared him for discharge home. R2 was recorded as, " to go back on his her, R2's Behavioral Access and 11/3/20, identified R2 his medications as they made out." R2 voiced he would go home and " be on my best the my medicine." R2 denied ations to hurt himself or others, having visual hallucinations at a clinical status was listed hly impulsive and aggressive to others. R2 was cleared to go home.  The results were derinfection and no new ment orders were provided. dt, "He is to see [nurse ys." | F 7                                | 40   |        |          |                            |
|                          | identified the pharm completed laborator his Clozapine [sic] possible." The pharm contact the hospita results and would conte concluded, "Wigharmacy." Further 11/4/20, identified to contacted. The pharm more information of been without his clothome expressed has   | equent progress note hacy had been updated on the bry draws, and R2 " needed medication as soon as macist voiced they would I to review the laboratory contact the nursing home. The friter is awaiting call back from an additional note, dated he pharmacy was again armacist voiced they needed in how many days R2 had ozapine; which the nursing ad been "two weeks since his" The pharmacist then   |                                    |  |        |          |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTI<br>A. BUILDIN  | PLE CONSTRUCTION  G | (X3) DATE SURVEY COMPLETED C   |           |                            |
|--|--|---|---------------------|--|-----------|----------------------------|
|  |  | 245438  | B. WING _           |  | l         | /18/2020                   |
|  | PROVIDER OR SUPPLIER  NURSING AND REHA   | AB CENTER   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304      |           |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORF<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETION<br>DATE |
| F 740  | who prescribed the to be re-titrated giv been off the medic message had been note concluded, "We pharmacist"  On 11/6/20, at 1:38 identified R2 was approximately 11:3 he was going to ge When he didn't coasked CNA to go smachine but CNA of from east [sic] and rooms and other all found him raping a for help. The 2 mal walked him back to of nursing] and chapolice were called a [1:30 a.m.]. For more adult] report."  R2's Medication Addated 10/2020 to 1 physician ordered is subsequent administration was listed for clozal everyday; which has the medication was consumed by R2 un 11/5/20, the MAR is doses of the medication was of the medication was entries o | eded to speak with the provider medication to see if it needed en the length of time R2 had ation. The pharmacist voiced a left for the provider, and the driter is awaiting a respond fro a.m. a progress note een coming out of his room at 0 p.m. (on 11/5/20) and voiced to a soda. The note continued, "come back in 15 minutes e if he was still by pop couldn't find him. Writer, nurse 2 CNA's split up to check all reas of the building [NA-A] female resident and screamed e CNA's pulled him off her and to his room. The DON [director arge RN were called. The and the police took him about one details see VA [vulnerable details | F 74                |  |           |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING   |                     |  | (X3) DATE SURVEY<br>COMPLETED |                            |  |
|--|--|---|---------------------|--|-------------------------------|----------------------------|--|
|  |  | 245438  | B. WING _           |  |                               | C<br>/ <b>18/2020</b>      |  |
|  | PROVIDER OR SUPPLIER   |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1717 UNIVERSITY DRIVE SOUTHEAST<br>SAINT CLOUD, MN 56304          |                               |                            |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE                         | (X5)<br>COMPLETION<br>DATE |  |
| F 740  | R2's Documentation to 11/2020, was represented behavior corresponding coordemonstrated R2 including hitting, the sexually inappropring September and Oda single episode of behavior recorded as, "disrupted [the re-directed but the No other behaviors these reports desprote(s) which idented by the redirected but the No other behaviors these reports desprote(s) which idented and wanded R2's medical recorded and the preduce and abrupt stopping of medication. There had implemented a monitoring or superantipsychotic mediand the ongoing dobehaviors, including being found mastured the incident involving the incident involv | age 64 on Survey Report, dated 9/2020 viewed and identified R2's is using a legend and the system. The report and no recorded behaviors, areatening, cursing at others or interest behaviors, in the month of otober 2020. However, R2 had if sexually inappropriate on 11/2/20 which was outlined environment." R2 was intervention was ineffective. It is were recorded for R2 on outlined him as cursing, throwing the aring around the facility.  In the was reviewed and lacked alating behaviors had been assessed to help determine all as and subsequent interventions and subsequent increased envision of R1 despite his cation being abruptly stopped becomentation of escalating apphysically throwing items and or identified before 11/2/20 in on 11/13/20, at 9:41 a.m. NA-A and explained R2 was more his needs and typically did not from the staff. NA-A recalled ang R2 and another resident aulted and explained R2 had | F 74                | 0  |                               |                            |  |

|                          | OF DEFICIENCIES OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MUL <sup>*</sup><br>A. BUILDI | TIPLE CONSTRUCTION ING  |                          |    | E SURVEY<br>PLETED         |
|--------------------------|---|--|------------------------------------|---|--------------------------|----|----------------------------|
|                          |   | 245438   | B. WING                            |   |                          |    | C<br><b>18/2020</b>        |
|                          | PROVIDER OR SUPPLIER  | B CENTER   |                                    | STREET ADDRESS, CITY, STATE, ZI<br>1717 UNIVERSITY DRIVE SOUTH<br>SAINT CLOUD, MN 56304 |                          |    |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                |   | ION SHOULD<br>HE APPROPI | BE | (X5)<br>COMPLETION<br>DATE |
| F 740                    | was going to walk of was gone for "about working (RN-B) had for R2 as he had "b days" and had not yshe opened a female saw R2 on top of he underwear on as he "having sex with he naked buttocks were her peri-area "movishe immediately ye but R2 just turned a continued assaultin voiced she yelled for members then respet the female resident room. NA-A explair and R2 was subsequiring home. Further never known R2 to prior, but verified he supervision or mon as 'acting weird' the During interview on described R2 as so care" and would oft home at night addir other resident' room verified R2 was fou on 11/5/20, and had resulted in the policing responded and inter RN-B, then "admitted resident" and mitted resident readmitted resident readmitted responded and inter RN-B, then "admitted resident" and resulted responded and inter RN-B, then "admitted resident" resident readmitted readmitted resident readmitted resident readmitted resident readmitted readmitted resident readmitted | inight of 11/5/20, voicing he down to the soda machine. R2 at 15 minutes" when the nurse d asked staff to start looking been acting weird the last few yet returned yet. NA-A stated ale resident's closed door and ar in her bed with no pants or a held her down and was ar." NA-A expressed R2's are visible immediately above ang up and down." NA-A stated alled at R2 to "get off of her," and looked at NA-A while he ag the female resident. NA-A for help and male staff bonded and removed R2 from as bed and took him back to his ned the police were contacted quently removed from the her, NA-A explained she had demonstrate sexual behaviors are was not on any formal itoring despite being identified a past few days.  11/13/20, at 10:20 a.m. RN-B ameone who "didn't need much are walk around the nursing ang R2 was not known to enter a few sexually assaulted her which are being contacted. The police arviewed R2 who, according to go the had done it" and was | F 7                                | 40  |                          |    |                            |
|                          | recalled R2 never t   | the nursing home. RN-B ypically demonstrated any gressive behaviors which she  |                                    |   |                          |    |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULT<br>A. BUILDIN   | PLE CONSTRUCTION  G | CON  | (X3) DATE SURVEY<br>COMPLETED |                            |  |
|--|--|---|---------------------|--|-------------------------------|----------------------------|--|
|  |  | 245438  | B. WING _           |  |                               | C<br>/ <b>18/2020</b>      |  |
|  | PROVIDER OR SUPPLIER   |   |                     | STREET ADDRESS, CITY, STATE, ZIP 1717 UNIVERSITY DRIVE SOUTHE SAINT CLOUD, MN 56304        | CODE                          | 110/2020                   |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTIOI<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | N SHOULD BE                   | (X5)<br>COMPLETION<br>DATE |  |
| F 740  | could recall, howe become "more rest the 11/5/20 incider and discharge from stated she was "not more restless and there had been received incident on 11/5/20 notes since he was the nursing home.  On 11/13/20, at 1: manager (RN)-A at (LSW)-A were intensing home after to discharge to a volume They described R2 never really identife to the weeks leading 11/5/20. LSW-A expressive with a daily review stand-up meeting. progress note (dat displayed no hallus behaviors at that the concerns" with him were actually unsure him as having rest meeting. LSW-A sonewer process and out" how to use the admitted using cloand consistently to 10/19/20, when he monitoring and the | ver, voiced R2 had seemed to otless" in the weeks leading up not and R2's subsequent arrest in the nursing home. RN-B to sure" why R2 had become expressed she "wasn't aware" corded notes outlining him as or masturbating prior to the D; however, had learned of the s arrested and removed from | F 74                |  |                               |                            |  |

|                          | OF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | . ,                |     | LE CONSTRUCTION   | ` ' | E SURVEY<br>PLETED         |
|--------------------------|--|--|--------------------|-----|---|-----|----------------------------|
|                          |  |  |                    |     |   | (   | 0                          |
|                          |  | 245438   | B. WING            |     |   | 11/ | 18/2020                    |
| NAME OF F                | PROVIDER OR SUPPLIER   |  |                    | S   | TREET ADDRESS, CITY, STATE, ZIP CODE  |     |                            |
| TALALII                  | NURSING AND REHA   | B CENTED   |                    | 1   | 717 UNIVERSITY DRIVE SOUTHEAST  |     |                            |
| IALAIII                  | NUNSING AND REHA   | B CENTER   |                    | S   | SAINT CLOUD, MN 56304   |     |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY) | BE  | (X5)<br>COMPLETION<br>DATE |
| F 740                    | days later (on 10/22 feel comfortable stare-dosing the cloza appointment with R made for as soon at then attempted to a telephone, however so she left a messare provided though an again attempted to as, at the time, she immediate danger. Supervision or mondespite abruptly stomedication; however intervention would be for someone who a medication. RN-A amedical record and explained the behas 10/19/20 were not a demonstrated prior assessment or discart the daily stand-urangle floor nurses documbe making sure the aware of them and been updated on the hallucinations, physmasturbation. They R2 sexually assault reiterated they had assessed all the dissince 10/19/20, included | se practitioner (NP)-B a couple 2/20) who voiced she did not arting new medication or pine and directed an 1/2's psychiatry team should be as possible. RN-A stated she contact the psychiatric team via 1/2, was unable to reach anyone age. A return call was never and RN-A verified she never contact the psychiatry provider 1/2 didn't feel anybody was in 1/2. They verified no increased itoring had been placed on R2 apping his antipsychotic er, RN-A added such an a good intervention to doubruptly ceased their and LSW-A then reviewed R2's 1/2 progress notes. They wiors being recorded after normal behaviors R2 had | F 7                | 740 | DEFICIENCY)   |     |                            |
|                          | updated on the beh   | reiterated if they had been naviors and known they were build have done some "more   |                    |     |   |     |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  |                     |   | (X3) DATE SURVEY COMPLETED C |                            |  |
|--|--|--|---------------------|---|------------------------------|----------------------------|--|
|  |  | 245438   | B. WING _           |   |                              | 18/2020                    |  |
|  | PROVIDER OR SUPPLIER   |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1717 UNIVERSITY DRIVE SOUTHEAST<br>SAINT CLOUD, MN 56304           | ,                            | 10.2020                    |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | _D BE                        | (X5)<br>COMPLETION<br>DATE |  |
| F 740  | comprehensive as the situation "a little added she "didn't lescalating like that contacted the facilitried to include the these crazy behave no changes were a from a room changincident involving lest "maybe some edur RN-A stated the bette management to address" in upon to 10/19/20, a ware of any behave being abruptly stop not personally order the prescriber is recertification." The relaboratory values the times, pharmac medication until the result of those thin psychiatry team we clozapine. NP-B estaboratory monitor provider service we days later on 10/22 medication orders the nursing home R2's psychiatry tear idea" what they order service we idea" what they order service idea" what they order service we idea" what they order service would be serviced in the service was a serviced in the service was a serviced what they order service was a serviced what they order service what they | sessment" of them and taken e more seriously." LSW-A know the behaviors were "and voiced she would have ity' psychiatry team (ACP) and m "if we [had been] aware of iors." RN-A and LSW-A verified made to R2's care plan, aside ge, from 10/19/20 until the R1 on 11/5/20 and added cation" was needed. Further, ehaviors not being forwarded to eam was something "we need oming nurses meetings.  12 p.m. R2's medical nurse was interviewed. R2 was "very reserved" and "quiet" and NP-B verified she was "not viors" prior to the clozapine oped. NP-B explained she did er or manage R2's clozapine as equired to have a special as "a very dangerous nedication required certain to be checked periodically and, ies would not even release the ese lab(s) were obtained. As a gs, NP-B stated R2's as managing his ordered explained when R2 refused the ing on 10/19/20, their on-call as notified about it a couple 2/20. NP-B voiced no new were given as she assumed thad already been in touch with am and she would have "no dered or did. On 10/31/20, were again notified R2's | F 74                |   |                              |                            |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   |  | (X2) MULTI<br>A. BUILDIN | PLE CONSTRUCTION  G   | COM       | (X3) DATE SURVEY COMPLETED C |  |  |
|--|---|--|--------------------------|---|-----------|------------------------------|--|--|
|  |   | 245438   | B. WING _                |   |           | /18/2020                     |  |  |
|  | PROVIDER OR SUPPLIER  |  |                          | STREET ADDRESS, CITY, STATE, ZIP C<br>1717 UNIVERSITY DRIVE SOUTHEA<br>SAINT CLOUD, MN 56304  | ODE       |                              |  |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETION<br>DATE   |  |  |
| F 740  | time, a three (3) da medication used for on 11/3/20, NP-B was now being ver "two weeks" without NP-B stated this whad not had his cloordered him to be nursing home felt than anymore. The ED laboratory draw(s) nursing home was clozapine restarted facility on 11/4/20, aware R2's psychian otified of his refus draw(s) and subservice had not be on clonazepam so helped to calm and he required treatm sexually assaulted  On 11/13/20, at 3:3 pharmacist (CP) we clozapine was a mother antipsychotic potentially dangerd special laboratory while the patient is wouldn't be a good medication without doing so could yiel schizophrenia symeffects. Further, C | to be worsening and, at that ay dose of clonazepam (a or anxiety) was provided. Then was updated again and told R2 ry aggressive and had gone for at his antipsychotic medication. The state of the stat | F 74                     |   |           |                              |  |  |

|                          |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |   |        | (X3) DATE SURVEY<br>COMPLETED |                            |
|--------------------------|---|---|---|---|--------|-------------------------------|----------------------------|
|                          |   | 245438  | B. WING                                 |   |        |                               | C<br>18/2020               |
|                          | PROVIDER OR SUPPLIER  | B CENTER  |   | STREET ADDRESS, CITY, STATE, ZIP CODE  1717 UNIVERSITY DRIVE SOUTHEAST  SAINT CLOUD, MN 56304 |        |                               | 10/2020                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                     |   | SHOULD | BE                            | (X5)<br>COMPLETION<br>DATE |
| F 740                    | had stopped taking then had a return or different antipsychologymptoms may have nursing home should when the patient readdress it.  On 11/17/20, at 11: (DON) was intervier received a telephore 11/6/20, and the state has happened whith R2 "raping our poor instructed them to an and then contacted on the allegation. The arrived at the nursing present and voiced for "sexual miscond police he committed removed from the removed from | on; however, explained if he the medication abruptly and f symptoms that perhaps a offic to help reduce or calm the re helped. CP added the ld have a policy on what to do fuses medications and how to as a.m. the director of nursing wed. The DON explained she he call shortly after midnight on aff voiced "something terrible on they described as finding refemale resident]." The DON contact the police department and updated the administrator he DON voiced when she had however as R2 admitted to the did the act. R2 was arrested and hoursing home. The DON upervision or safety checks despite him abruptly stopping edication and having ating behaviors recorded in his the DON stated masturbation, in not be considered behavioral the end of him being found doing it by a stay prior to 11/2/20. The converted and no prior history of sexual nowledge and they were trying | F 7                                     | ,   |        |                               |                            |
|                          | not required skilled becoming upset with  | placement for him as he did<br>care. R2 did have a history of<br>th his roommate(s) though<br>like television volume, so they   |   |   |        |                               |                            |

|                          | OF DEFICIENCIES OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |         |  | LE CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                            |
|--------------------------|---|--|---------|--|---|-------------------------------|----------------------------|
|                          |   |  | 7 50.25 |  |   | (                             | C                          |
|                          |   | 245438   | B. WING | ;  |   | 11/                           | 18/2020                    |
|                          | PROVIDER OR SUPPLIER  NURSING AND REHA  | B CENTER   |         |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1717 UNIVERSITY DRIVE SOUTHEAST<br>SAINT CLOUD, MN 56304 |                               |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  |         | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFILE OF THE APPROPROPROFILE OF THE APPROPROFILE OF THE APPROPRO |   | BE                            | (X5)<br>COMPLETION<br>DATE |
| F 740                    | just prior to the ass at times and would, when he was irritate had heard about R2 clozapine when sta and a nurse reporter medication to give. date she was first to his prescribed clozashe was not told un sexual assault of the voiced her expectation informed the same laboratory draw and medication not provided the several transpectory tests, but DON then reviewed attempted several transpectory tests, but DON then reviewed and address document added her expectate to review the progressible triggers, particularly to the reviewed and addressible triggers. The polyword and LSW-A were respectively to the reviewed and the reviewed | ge 71 to move him to a private room ault as R2 was "unpredictable" at times, get aggressive ed. The DON explained she end they did not have the She could not recall the exact old R2 had not been getting apine, but felt "pretty confident" til the week just prior to the e female resident. The DON tion would have been to be day he initially refused the disubsequently had his wided. The DON stated she of ensure the guardian and did not he situation, and they imes to draw the needed to R2 would not allow it. The R2's progress note(s) in his fied there were "more inted" after 10/19/20, and in was for RN-A and LSW-A eas notes "each day" and bring lating behaviors and missed IDT meeting so they can be eased including reviewing for eatterns and other issues. The missed doses of clozapine at their IDT meetings and seues been presented at the did have intervened" and made eation was taken adding RN-A exponsible to ensure the lessed and "put all that all stated those assessments multiple interventions which en attempted to help ensure | F       | 740  |   |                               |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | A. BUILDIN   | IPLE CONSTRUCTION IG |   | (X3) DATE SURVEY<br>COMPLETED |                            |  |
|--|---|--|----------------------|---|-------------------------------|----------------------------|--|
|  |   | 245438   | B. WING _            |   | 11                            | C<br>/ <b>18/2020</b>      |  |
|  | PROVIDER OR SUPPLIER  |  |                      | STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304             |                               | 110/2020                   |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPI<br>DEFICIENCY) | ULD BE                        | (X5)<br>COMPLETION<br>DATE |  |
| F 740  | residents, including and protected from A Sherburne Count 11/17/20, identified jail system with two charges included a degree assault; and degree criminal sed date was recorded amount was posted.  During the abbrevi 11/18/20, multiple interview NP-A regincident which hap was found in R1's missed return call a message was let interview would no 12/2/20, at 1:41 p.1 verified she helped for the duration of NP-A described R2 often displayed pohealth. NP-A recal 8/27/20, where a svoiced R2 was doi concerning behavi was notified on 10/1 laboratory draw an ordered clozapine; vacation at the tim updated. NP-A sta have re-contacted received back as a abruptly could dempsychotic symptom | g R2 himself, were kept safe in his escalating behaviors.  Ity Inmate Locator, printed It R2 as a current inmate of the orcharges listed. These in misdemeanor charge for 5th d, a felony charge of 3rd xual conduct. R2's custody as 11/6/20, and no bail | F 74                 |   |                               |                            |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION A. BUILDING |  |        | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|--|---|--|--|--------|-------------------------------|----------------------------|
|   |  | 245438  | B. WING                                |  |        |                               | C<br><b>18/2020</b>        |
|   | PROVIDER OR SUPPLIER   | B CENTER  |  | STREET ADDRESS, CITY, STATE, ZIP C<br>1717 UNIVERSITY DRIVE SOUTHEA<br>SAINT CLOUD, MN 56304 |        |                               |                            |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG                     |  | SHOULD | BE                            | (X5)<br>COMPLETION<br>DATE |
| F 740   | of R2's escalating by voiced had their clir have started other roptions available." I antipsychotic medic have side effects wor desire and if they contribute to those R2 been medicated "helped him to mak potentially not sexu."  A provided Behavior 5/2017, identified a residents who exhibit their physical and policy directed, "The will address resider comprehensive plane listed which directed assessed upon addressessed upon addressessed upon addresses and the of developed to reduct of behavioral symptomic directed to reassessed behavioral symptomic and the of the symptomic symptom | P-A stated she was unaware behaviors after 10/19/20, and nic been updated, they would medications as "their were NP-A expressed many cations, including clozapine, which can reduce sexual urge y're abruptly stopped it could desires returning, adding had dispropriately it may have to better decisions" and hally assault a female resident.  Or Management policy, dated purpose of identifying bit behaviors which decrease beychosocial well-being. The e interdisciplinary team [IDT] in the behaviors in the resident's in of care." A procedure was did the resident would be mission, quarterly and upon a for factors which contribute to care plan would then be see and/or eliminate the cause toms. Further, the policy is residents identified with mis at least quarterly or " deemed necessary by the IDT edical record. |  | 380  |        |                               | 12/23/20                   |
| SS=F  | CFR(s): 483.80(a)(<br>§483.80 Infection C<br>The facility must es<br>infection prevention<br>designed to provide   | 1)(2)(4)(e)(f)  |  |  |        |                               | 12/20/20                   |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | l ' '  | IPLE CONSTRUCTION  IG |  | (X3) DATE SURVEY<br>COMPLETED |                            |  |
|--|--|--|-----------------------|--|-------------------------------|----------------------------|--|
|  |  | 245438   | B. WING _             |  | 11                            | C<br>/18/2020              |  |
|  | PROVIDER OR SUPPLIER   | AB CENTER  |                       | STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304  | •                             | , 10, 2020                 |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APF DEFICIENCY) | OULD BE                       | (X5)<br>COMPLETION<br>DATE |  |
| F 880  | development and to diseases and infection program. The facility must estand control program a minimum, the following states and control program a minimum, the following states and control program a minimum, the following states and commercial states and commercial states and commercial states and commercial states are not limited and states are not limited states a | ransmission of communicable tions.  In prevention and control  Stablish an infection prevention (IPCP) that must include, at lowing elements:  Item for preventing, g, investigating, and controlling municable diseases for all unteers, visitors, and other g services under a contractual dupon the facility assessmenting to §483.70(e) and following standards;  Item standards, policies, and program, which must include, to:  Item includes or relevant process of relevan | F 88                  |  |                               |                            |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | . ,                 | E CONSTRUCTION 6   | COMPLETED                                    |
|--|--|---|---------------------|--|--|
|  |  | 245438  | B. WING             |  | C<br><b>11/18/2020</b>                       |
|  | PROVIDER OR SUPPLIER   |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  1717 UNIVERSITY DRIVE SOUTHEAST  SAINT CLOUD, MN 56304  | 11/10/2020                                   |
| (X4) ID<br>PREFIX<br>TAG                         | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPR<br>DEFICIENCY)  |  |
| F 880  | (v) The circumstar must prohibit emp disease or infected contact with reside contact will transm (vi)The hand hygie by staff involved in §483.80(a)(4) A syidentified under the corrective actions §483.80(e) Linens Personnel must hat transport linens so infection.  §483.80(f) Annual The facility will con IPCP and update This REQUIREME by:  Based on observative review, the failed the environmental clear procedures according according to the facility. In additional staff correctly work (PPE) during daily residents (R4 and precautions and the hygiene while work R6, and R7) room service in the mentacility failed to enfacility failed to e | loyees with a communicable d skin lesions from direct ents or their food, if direct nit the disease; and ene procedures to be followed a direct resident contact.  In the disease is and ene procedures to be followed a direct resident contact.  In the disease is and ene procedures to be followed a direct resident contact.  In the disease is and ene procedures to be followed a direct resident contact.  In the disease is and the facility is IPCP and the taken by the facility.  In the disease is and the facility is IPCP and the taken by the facility. | F 880               | " PERSONAL PROTECTIVE EQUIPMENT (PPE) o R4, R5, R6, R7 are no longer or droplet precautions. o All residents have the potential taffected by staff not wearing PPE appropriately. Facility will identify an residents who require droplet precaund designate appropriate signage in doorway of their room and have ade PPE available outside of the room with disposal containers available inside room. o Staff education: nursing home so educated on the importance of wear PPE appropriately prior to entering a resident is room for all departments. | o be  y utions n the quate vith the taff ing |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION A. BUILDING |     |   | (X3) DATE SURVEY<br>COMPLETED                            |                            |
|---|--|---|--|-----|---|--|----------------------------|
|   |  | 245438  | B. WING                                |     |   | 11/1   | 8/2020                     |
| NAME OF F   | PROVIDER OR SUPPLIER   |   |  | S   | TREET ADDRESS, CITY, STATE, ZIP CODE  |  |                            |
| <b>TALALI</b>                                       | UIDONIO AND DELL   | AD OFWED  |  | 1   | 717 UNIVERSITY DRIVE SOUTHEAST  |  |                            |
| IALAHII   | NURSING AND REH  | AB CENTER   |  | S   | SAINT CLOUD, MN 56304   |  |                            |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG                     |     | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   |  | (X5)<br>COMPLETION<br>DATE |
| F 880   | residents) was may (R8, R9, R10, R11, R17, R18) eating of memory care unit. all 21 residents result the time of the first the first the time of the first th | intained for 11 of 12 residents, R12, R13, R14, R15, R16, during meal service in the This had the potential to affect siding in the memory care unit occused infection control survey.  L CLEANING/CHEMICAL  Daily Census report indicated at 14 day admission quarantine | F 8                                    | 380 | ,   | ives ection lated  Elines in ection ership g PPE ns i.e. |                            |
|   | R4's room with the small trash can of contents of can int  | same PPE on and carried a used gowns and dumped to the housekeeping cart's e and returned the garbage can   |  |     | ¿ The Director of Nursing, Infection Preventionist, and other facility lead will conduct routine audits of source control for staff, visitors, and resider  | ership   |                            |
|   | with the same line<br>time, H-A's gown with the front of the gove<br>gown ties made me<br>floor as she bent of<br>H-A exited the roo   | r back into R4's room. At that was untied and hung down from wn. At 9:43 a.m. the untied ultiple direct contacts with R4's over to clean R4's wheelchair.  m, removed gown and gloves   |  |     | all shifts four times a week for one very then twice weekly for x 3 weeks, the weekly x 1 months.  ¿ The Director of Nursing, Infection Preventionist, and other facility leads will conduct real time audits on all agrees | week,<br>en<br>on<br>ership                              |                            |

|               | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:          | l ` ′         | IPLE CONSTRUCTION<br>IG   |              | (X3) DATE SURVEY<br>COMPLETED |  |
|---------------|-------------------------------|---|---------------|---|--------------|-------------------------------|--|
|               |                               |   | A. DOILDII    |   |              | c                             |  |
|               |                               | 245438  | B. WING _     |   |              | 18/2020                       |  |
| NAME OF F     | PROVIDER OR SUPPLIEF          | ₹   |               | STREET ADDRESS, CITY, STATE, ZIP COL  |              | 10/2020                       |  |
|               |                               |   |               | 1717 UNIVERSITY DRIVE SOUTHEAST   |              |                               |  |
| TALAHI I      | NURSING AND REH               | AB CENTER   |               | SAINT CLOUD, MN 56304   |              |                               |  |
| (X4) ID       | SUMMARY ST                    | TATEMENT OF DEFICIENCIES                                    | ID            | PROVIDER'S PLAN OF CORRI  | ECTION       | (X5)                          |  |
| PREFIX<br>TAG | (EACH DEFICIENC               | CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | PREFIX<br>TAG |   | HOULD BE     | COMPLÉTION<br>DATE            |  |
| F 880         | Continued From p              | page 77   | F 88          | 30  |              |                               |  |
|               | housekeeping car              | t garbage. H-A did not perform                              |               | ensure PPE is in use, 3 x wee   | k x 1 month, |                               |  |
|               | hand hygiene.                 |   |               | then weekly x 1 months.   | ŕ            |                               |  |
|               |                               | H-A donned gloves, entered                                  |               | o Audit results to be reviewe   | ∍d at        |                               |  |
|               | R6's room, and cle            | eaned off the tray table and the                            |               | monthly QAPI to evaluate the  |              |                               |  |
|               |                               | et rag. H-A exited R6's room at                             |               | effectiveness of audit continua   |              |                               |  |
|               |                               | ed gloves, grabbed a roll of toilet                         |               | o Responsible for audits: Di  | rector of    |                               |  |
|               |                               | rt, and brought the toilet paper                            |               | Nursing or designee   |              |                               |  |
|               |                               | it's room a few doors down. H-A                             |               | 0<br>" FOLUDMENT/ENI//IBONIA  | 4ENIT        |                               |  |
|               |                               | and hygiene after glove removal.                            |               | EQUIPIVIEN I/ENVINONIV  |              |                               |  |
|               |                               | H-A used non-gloved hands to of a wheeled walker located    |               | o R4, R5, R6, R7 are no lon   | ger on       |                               |  |
|               |                               | om and moved it to the right                                |               | droplet precautions.  o All residents have the potential.                         | ential to be |                               |  |
|               |                               | ay isolation bin. H-A then                                  |               | affected by staff not wearing F   |              |                               |  |
|               |                               | sket of therapy supplies located                            |               | appropriately, not completing   |              |                               |  |
|               |                               | alker's seat directly to the floor                          |               | hygiene appropriately, and col  |              |                               |  |
|               |                               | alker. At 9:55 a.m. H-A sprayed                             |               | dining occurring within 6 feet of   |              |                               |  |
|               | a solution on the v           | valker and at 9:55 a.m. she                                 |               | other. Facility will identify any   |              |                               |  |
|               | used non-gloved h             | nands to wipe the solution off                              |               | who require droplet precaution  | าร and       |                               |  |
|               |                               | -A failed to perform hand                                   |               | designate appropriate signage   |              |                               |  |
|               |                               | nediately after wiping off the                              |               | doorway of their room and have  |              |                               |  |
|               |                               | the solution used was                                       |               | PPE available outside of the r  |              |                               |  |
|               |                               | explained the Sani-Clean 2                                  |               | disposal containers available i   | nside the    |                               |  |
|               |                               | urfaces and left for "5 to 10                               |               | room.   |              |                               |  |
|               | minutes" before b             |   |               | <ul> <li>The director of housekeep<br/>of maintenance, and director of</li> </ul> |              |                               |  |
|               |                               | H-A donned gloves without                                   |               | -   | •            |                               |  |
|               |                               | hand hygiene and entered R7's ng donned a gown. H-A         |               | have reviewed policies and pr<br>regarding disinfecting multiuse                  |              |                               |  |
|               |                               | arbage can of used gowns and                                |               | equipment/items and/or enviro   |              |                               |  |
|               |                               | ents of the garbage can into the                            |               | disinfection to ensure they me  |              |                               |  |
|               |                               | t's uncovered garbage, which                                |               | guidance for disinfection in he   |              |                               |  |
|               |                               | middle of the hallway, and                                  |               | facilities and follow disinfectar   |              |                               |  |
|               |                               | pack into R7's room. At 9:57                                |               | manufacturer directions for us  |              |                               |  |
|               | a.m. H-A opened               | R7's bathroom door with her                                 |               | contact time.   | 9            |                               |  |
|               |                               | ed around when NA-E   |               | o Staff education: staff resp   |              |                               |  |
|               |                               | doorway with a fresh water                                  |               | resident care equipment and   |              |                               |  |
|               |                               | the mug to R7. H-A exited R7's                              |               | have been trained on the facil  | •            |                               |  |
|               |                               | mug and placed it on a top                                  |               | policies/practices for proper d   |              |                               |  |
|               |                               | sekeeping cart. H-A touched                                 |               | including following manufactur  |              |                               |  |
|               | multiple cloth mop            | heads located on top of the                                 |               | for use. Each staff persor  | า has        |                               |  |

PRINTED: 12/31/2020 FORM APPROVED OMB NO. 0938-0391

| CENTERS FOR MEDICARE & MEDICAID SERVICES |  | & MEDICAID SERVICES  |                     |     | UI  | <u>NB NO.</u>  | 0938-0391                  |
|--|--|--|---------------------|-----|---|--|----------------------------|
|  | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | l ` ′               |     | E CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED  |                            |
|  |  | 0.45.400   | B WING              |     |   |  |                            |
|  |  | 245438   | B. WING             |     |   | 11/1   | 8/2020                     |
| NAME OF F                                | PROVIDER OR SUPPLIER   |  |                     | ST  | FREET ADDRESS, CITY, STATE, ZIP CODE  |  |                            |
| ΤΔΙ ΔΗΙΙ                                 | NURSING AND REHA   | B CENTER   |                     | 17  | 717 UNIVERSITY DRIVE SOUTHEAST  |  |                            |
| IALAIIII                                 | NONOINO AND INEINA   | D OLIVIER  |                     | S   | AINT CLOUD, MN 56304  |  |                            |
| (X4) ID<br>PREFIX<br>TAG                 | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFI)<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY)   | BE   | (X5)<br>COMPLETION<br>DATE |
| F 880                                    | cart with a gloved hup. Instead, she do failed to perform ha across the hall to Rhaving touched R6' exited R6's room we cleaner and entered H-A cleaned R6's to chemical to sit prior multiple clean dry or gloved hands once wiped down most the wet rag; however, for Again, H-A touched cart with her gloved R7's bathroom, cleated glass cleaner 10:01 a.m. H-A touched to the bathroom. At 10 H-A and questioned acknowledged NAcleaning in R7's root that time. Immediat H-A, H-A removed hand hygiene, and NA-E. H-A failed to she touched R7's many cleaner onto R5's we right away after appropriate the second sec | and; however did not pick one nned a new pair of gloves, and hygiene, and walked 6's room and entered after s room door handle. H-A ith a spray can of glass d R7's bathroom. At 9:59 a.m. bilet without allowing the to flushing, and touched leaning rags on the cart with she exited the room. H-A nings in the bathroom with a ailed to wipe down the sink. I multiple things located on the I hands and again entered aned the mirror with a eaner, and then used the to clean out the sink. At ched a stack of clean rag and a the cart with gloved hands at rag to clean off the light in 0:02 a.m. NA-E approached d her on lack of gown use. H-A E; however, had finished om and did not don a gown at the gloves, failed to perform handed R7's old water mug to perform hand hygiene after nug.  H-A donned gloves, entered ayed an instant action foaming wheelchair which she wiped off | F 8                 | 880 | demonstrated competency at the conclusion of the training. Staff are checked off on a staff roster to valid applicable staff have completed the education and competency.  o Audits:  ¿ The Director of Nursing, the Inf Preventionist, and/or other facility leadership will conduct audits for precleaning and disinfection of resider equipment/environmental cleaning shifts every day for one week, 3x weeks, then weekly x 1 month.  o Audit results to be reviewed at monthly QAPI to evaluate the effectiveness of audit continuation on Responsible for audits: Directon Nursing or designee  "HAND HYGIENE  o R4, R5, R6, R7 are no longer of droplet precautions.  o All residents have the potential affected by staff not completing has hygiene appropriately.  o The Infection Preventionist/Director Nursing have reviewed hand hygien policies and procedures to ensure the meet CDC guidance.  o Staff education: training has becompleted for the Infection Prevent the Director of Nursing, all staff prodirect care to residents, and all staff entering resident some services. The training maintenance services. The training maintenance services. The training has not considered to the training heads or clear and maintenance services. The training heads of the training heads or clear and maintenance services. The training heads of the training heads or clear and maintenance services. The training heads or clear and maintenance services. The training heads of the training heads or clear and maintenance services. The training heads of the training heads or clear and maintenance services. The training heads of the training heads or clear and maintenance services. The training heads of the trai | date all election roper at use on all elector of the chey en cionist, viding for it be aning |                            |
|  | observation H-A ho   | usekeeper H-A was observed<br>fter having washed the carpet  |                     |     | covers standard infection control practices, including transmission-based   |  |                            |

with a carpet cleaner and proceeded down the

precautions and adequately caring for and

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| CENTER                   | RS FOR MEDICARE   | & MEDICAID SERVICES  |  |     | Ol   | <u>MB NO.</u>                      | 0938-0391                  |
|--------------------------|---|--|--|-----|--|------------------------------------|----------------------------|
|                          | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | ' '  |     | E CONSTRUCTION   | COMI                               | SURVEY<br>PLETED           |
|                          |   | 245438   | B. WING  |     |  |                                    | C<br>18/2020               |
| NAME OF F                | PROVIDER OR SUPPLIER  |  |  | S   | TREET ADDRESS, CITY, STATE, ZIP CODE   | ,                                  | 10/2020                    |
|                          |   |  |  |     | 717 UNIVERSITY DRIVE SOUTHEAST   |                                    |                            |
| TALAHI I                 | NURSING AND REHA  | B CENTER   |  |     | SAINT CLOUD, MN 56304  |                                    |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG  |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY)  | BE                                 | (X5)<br>COMPLETION<br>DATE |
| F 880                    | F 880 Continued From page 79 hallway to a housekeeping room where she returned with more cleaner solution. H-A had a gown on and no gloves. The gown ties at H-A's  |  |  | 380 | disinfecting shared medical equipm o The Infection Preventionist, Dir of Nursing/Clinical Education Coord  | ector                              |                            |
|                          | gown on and no gloves. The gown ties at H-A's waist were not tied which exposed the H-A's uniform back. H-A stepped a few feet into R5's room with the gown on, failed to perform hand hygiene, and prepped the cleaner for operation. At 10:21 a.m. H-A entered the room's main living section where R5 was seated in a recliner, about 2 feet from her wheelchair. H-A grabbed R5's |  |  |     | or designee have completed compe<br>assessments for staff on proper ha<br>hygiene. Staff are checked off on a<br>roster to validate all applicable staff<br>completed the education and<br>competency.   | etency<br>nd<br>staff              |                            |
|                          | wheelchair, brough<br>removed the gown<br>the hallway to the h<br>the housekeeping r<br>the cart's uncovere<br>feet from the cart a   | t it out into the hallway, and as she started to walk down ousekeeping cart located by oom. H-A threw the gown in d garbage at approximately 3 and returned to Westwood  |  |     | o Audits: ¿ The Director of Nursing, the Inf Preventionist and other facility lead will conduct audits on all shifts, eve for one week, 3x week x 3 weeks, t weekly x 1 month. o Audit results to be reviewed at   | ership<br>ry day                   |                            |
|                          | gown removal. After sections of the gow the top of the garbaend of the garbage  | perform hand hygiene after r being placed in the garbage, n remained exposed above age and hung down over the can.  H-A entered R5's room and  |  |     | monthly QAPI to evaluate the effectiveness of audit continuation o Responsible for audits: Directo Nursing or designee   | r of                               |                            |
|                          | proceeded to touch<br>cleaned the carpet:<br>foot board and cove<br>pockets. At 10:29 a<br>carpet, turned off the   | the following items as she R5's walker, tray table, bed ering, door edge, her uniform .m. H-A finished cleaning the light by the doorway, and H-A failed to perform hand   | o R8, R9, R10, F<br>R15, R16, R17, R1<br>participating in com<br>they are at least 6 t<br>service. |     | o R8, R9, R10, R11, R12, R13, F R15, R16, R17, R18 are no longer participating in communal dining ur they are at least 6 feet apart for me service.  o All residents who participate in  | R14,<br>iless<br>al                |                            |
|                          | When interviewed of stated she was requentered a resident of precaution signage not tied the gown of R4 and R7's rooms the required PPE with H-A acknowledged   | on 11/18/20, at 10:29 a.m. H-A uired to wear PPE when she room designated with droplet. H-A acknowledged she had brrectly when she worked in and that she did not wear all then in R7's room. Further, the numerous episodes of and lack of hand hygiene |  |     | communal dining or activities have potential to be affected.  o Nursing home staff educated o importance of completing hand hyg appropriately, and communal dining occur at least 6 feet apart for reside o Policies for social distancing ar residents and staff, social distancin during dining/activities were review o Residents will be monitored for | n the iene g must ents. mong g ed. |                            |

Facility ID: 00614

| CLIVIL        | TO I OIL MILDICAIL   | A MEDICAID SERVICES  |                      |     | U  | MID NO.  | 0930-0391          |
|---------------|--|--|----------------------|-----|--|--|--------------------|
|               | OF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MUI<br>A. BUILD |     | E CONSTRUCTION   |  | SURVEY<br>PLETED   |
|               |  |  |                      |     |  |  |                    |
|               |  | 245438   | B. WING              | i   |  | ı  | 18/2020            |
| NAME OF F     | PROVIDER OR SUPPLIER   |  |                      | S   | TREET ADDRESS, CITY, STATE, ZIP CODE   |  |                    |
|               |  |  |                      | 1   | 717 UNIVERSITY DRIVE SOUTHEAST   |  |                    |
| TALAHII       | NURSING AND REHA   | B CENTER   |                      | s   | SAINT CLOUD, MN 56304  |  |                    |
| (X4) ID       | SUMMARY STA  | TEMENT OF DEFICIENCIES   | ID                   | Ь   | PROVIDER'S PLAN OF CORRECTION  | N  | (X5)               |
| PREFIX<br>TAG | (EACH DEFICIENCY   | MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | PREF<br>TAG          |     | (EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY)  | ) BE   | COMPLETION<br>DATE |
| F 880         | when she worked be rooms, along with he R4 and R7 out in the on the gowns did not updated he   | between R4, R5, R6, and R7's having worn the gown used in he hallway. H-A stated the ties of "fit around me" and that she her supervisor about this. H-A   | F 8                  | 880 | ability to understand or willingness comply with social distancing and oplan interventions to promote compresidents who are unable or unwill comply will be educated, re-educated.   | care<br>oliance.<br>ling to<br>ed, and                               |                    |
|               | voiced if the gown to was a risk of "poter around" the room. If forgotten to put the room and voiced showever, stated showeve | ies touched the floor there stially contaminating things H-A explained she had gown on prior to entering R7's he should have worn it; he did not think her incorrect ther residents as she was "just and the floors." H-A voiced of what the word droplet recautions. H-A stated she erform hand hygiene before exiting a resident room or litems on her cart after she contaminated items. Further, |                      |     | redirected related to social distance of Staff education: all staff have be trained on the importance of social distancing of residents/staff/discontinuation of communal dining and activities. Stocked off on a staff roster to valial applicable staff have completed the education and competency. Staff unavailable to complete education compliance date will complete the education prior to working their new scheduled shift after the compliance of Audits:  ¿ The Director of Nursing, the Interest of Staff Complete Com | aff are date all by the date.  |                    |
|               | H-A explained she was expected to wear gloves when cleaning and she should remove the gloves also before touching items on her cart. In addition, H-A stated she was further expected to wear the gowns only inside a resident room and that the used gowns were not to be worn in the hallways. Additionally, H-A stated she should not have placed the gown haphazardly in the cart garbage as this should have been removed before she exited R7's room and disposed of correctly. H-A voiced she had never been told she was to tie the garbage bags in the residents room before exiting the room; however, did state this would be a good practice as "it could be contaminated." H-A explained she had used a Rest Stop toilet bowel cleaner to clean R7's toilet. H-A stated the manufacturer recommendation for use was to wait 10 minutes; however, H-A explained, "I do at least 5." H-A stated she used ZenaCrystal Glass Cleaner in R7's bathroom and   |  |                      |     | Preventionist and other facility lead will conduct rounds throughout the on each shift to ensure social distate being maintained by all staff and reduring various times of day and duvarious activities. The rounds will be conducted every day for four week weekly x 1 months.  o Audit results to be reviewed at monthly QAPI to evaluate the effectiveness of audit continuation or Responsible for audits: Director Nursing or designee  | lership<br>facility<br>ncing is<br>esidents<br>ring<br>be<br>s, then |                    |

|                          | F OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` ′     | TIPLE CONSTRUCTION  NG  | COMPLETED |                            |
|--------------------------|---|---|---------|---|-----------|----------------------------|
|                          |   | 245438  | B. WING |   |           | C<br>1/18/2020             |
|                          | PROVIDER OR SUPPLIER  |   |         | STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304     |           | 1710/2020                  |
| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  |   |         | PROVIDER'S PLAN OF CORREC ( (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE   | (X5)<br>COMPLETION<br>DATE |
| F 880                    | she acknowledged explained glass cleg glass surfaces and Sani-Clean 2 on the instructions for use verbalized it should 10 minutes. H-A act the Sani-Clean on addition, H-A voice on the chemicals showever, she tries best she can.  During interview or housekeeping direct was the main chemical facility, especially it explained the process was to spray it or three minutes, and that it air dries; how manufacturer instruanywhere from 8 of staff could not leave due to "people wall housekeeping also foaming cleaner for Sani-Clean 2 was a directions for use of about 2 minutes; hexamined, the instructions for use of a directions that much time that long. HD acknowledge to housekeeping also follow the manufly however, explained number of housekeeping also followed the manufly however, explained number of housekeeping also followed the manufly however, explained number of housekeeping also followed the manufly however, explained number of housekeeping also followed the manufly however, explained number of housekeeping also followed the manufly however, explained number of housekeeping also followed the manufly however. | using this on the sink. H-A caner was to only be used on she should have used e sink instead. H-A read the of the Sani-Clean and difference was to calculate the sani-Clean and difference was expected to use of the therapy wheeled walker. In difference was expected to use; to keep things cleaned the sani-Clean 2 mical used for cleaning in the more resident bathrooms. HD ess when she used Sani-Clean a surface, let it sit for two to then wipe it off "a little bit" so wever, HD acknowledged the actions were for it to stay wet ar 10 minutes. HD explained her to it on the surfaces that long king around." HD stated used an instant action ar other surfaces the not used on. HD explained the were to keep on surfaces for owever, when the can was ructions directed for staff to let hD explained her staff did not use to let it sit on surfaces for owledged staff were expected facturer instructions for use; did ue to work load and the eleping staff available, if staff facture instructions for let not get all of their required | F 8     | 80  |           |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION A. BUILDING |           |  | COV   | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--|---|--|-----------|--|-------|-------------------------------|--|
|   |  | 245438  | B. WING                                |           |  |       | C<br>/ <b>18/2020</b>         |  |
|   | PROVIDER OR SUPPLIE  |   |  |           | S, CITY, STATE, ZIP CODE<br>TY DRIVE SOUTHEAST<br>), MN 56304                                | ·     |                               |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG                     | X (EACH C | VIDER'S PLAN OF CORRECTI<br>CORRECTIVE ACTION SHOUI<br>EFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE | (X5)<br>COMPLETION<br>DATE    |  |
| F 880   | cleaning work cornhaving had converted administration ab frame concerns for facility. HD stated expected to wear should be removed not worn outside she expected state hand hygiene as she expected how PPE as directed a gowns by removing prior to placing the HD verbalized if some control practices is a serious infect contaminated and everything," and, denied she has poshe "does not have up" on her staff. It trained on the Sa | impleted each day. HD denied ersations with the current out the cleaning instruction time or the chemicals used in the housekeeping staff were all PPE as instructed, which ed inside the residents room and the room. Further, HD explained ff to wear gloves and perform directed. In addition, HD stated usekeeping staff to dispose of and to dispose of used PPE and the bag from the trash can be garbage bag in the cart trash. It is did not follow infection as directed she "would think that ion control issue as you have dexposed all those people to "everyone could be sick." HD erformed any recent audits as the time to do them or "follow her staff had been in-Clean approximately five ever, stated she does not | F                                      | 80        |  |       |                               |  |
|   | director of nursing does all the clean expected to follow as the facility use products. Further were expected to wear PPE as dire removed prior to on transmission be was disposed of a stated if staff were   | d on 11/18/20, at 2:08 p.m. the g (DON) stated housekeeping ing; however, all staff were with the manufacturer instructions d a "variety" of cleaning, the DON explained all staff perform hand hygiene and to cted, that gowns were to be exiting resident rooms identified based precautions, and that PPE also as directed. The DON er not following infection control was a potential for them to   |  |           |  |       |                               |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |   |          | (X3) DATE SURVEY COMPLETED C |  |
|--|---|---|---|---|----------|------------------------------|--|
|  |   | 245438  | B. WING _                               |   |          | /18/2020                     |  |
|  | PROVIDER OR SUPPLIER  |   |   | STREET ADDRESS, CITY, STATE, ZIP CO<br>1717 UNIVERSITY DRIVE SOUTHEAS<br>SAINT CLOUD, MN 56304    | DE       |                              |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF CORR<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE AF<br>DEFICIENCY) | HOULD BE | (X5)<br>COMPLETION<br>DATE   |  |
| F 880  | "spread infection to<br>A Sani-Clean 2 mainstructed staff for<br>"Let solution rema<br>10 minutes. Rinse<br>A Rest Stop restro<br>information sheet,<br>toilet bowls were or<br>remain on surface<br>minutes; then flush<br>A ZenaCrystal glass<br>information sheet,   | anufacturer label, undated disinfecting and cleaning to, in on surface for a minimum of or allow to air dry."  som disinfectant manufacturer undated instructed staff when cleaned to, "Allow product to for a contact time of 10 in toilet."  ss cleaner manufacturer undated, indicated, "use to dows, automotive glass, and  | F 88                                    | 30  |          |                              |  |
|  | 1:08 p.m. NA-D with dining room table p.m. NA-D fed R8 designated hand for R9's hands as she liquid. At 1:14 p.m. plate of R9. At 1:1 with a napkin using silverware with her R9. NA-D did not put these observations - At 1:18 p.m. carrying a resident metal cart of other sat next to R8 and At 1:19 a.m. NA-C | d observation on 11/18/20, at was seated at the corner of a feeding R8 and R9. At 1:11 and R9 without using a or each resident. NA-D touched assisted her to hold a glass of NA-D touched the divided 6 p.m. NA-D wiped R8's face g her right hand, picked up R9's right hand, and started to feed perform hand hygiene during s. NA-C entered the dining room to room tray and placed it in a sused meal trays. After, NA-C took over assisting R8 to eat. approached R10 and touched verware, and placed a cup in |   |   |          |                              |  |

| [`` '                    |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MUL <sup>-</sup><br>A. BUILDI | FIPLE CONSTRUCTION  NG   |        | TE SURVEY MPLETED  C       |
|--------------------------|---|--|------------------------------------|--|--------|----------------------------|
|                          |   | 245438   | B. WING                            |  | 11     | /18/2020                   |
|                          | PROVIDER OR SUPPLIER  |  |                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1717 UNIVERSITY DRIVE SOUTHEAST<br>SAINT CLOUD, MN 56304          | ,      |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                | PROVIDER'S PLAN OF CORREC' ( (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPROPRIED DEFICIENCY) | JLD BE | (X5)<br>COMPLETION<br>DATE |
| F 880                    | his hand. Immediate R11 and touched R11 and touched R8, touched her own picked up R8's silk hand hygiene during - At 1:21 p.m. with her right hand same hand. At 1:2 R12 and handed heremoved his meal placed the meal traknocked over cups floor. After NA-D pR14 down to the dR14 a cup of coffer R14 immediately on the perform hand be observations.  -At 1:28 p.m. Not trays, handed R9 and from. When cleaned R9's mouth protector. NA-C brown the designated lau with bare hands to own hair, took off a protector and placemetal cart. At 1:31 belt on R10 and trays. | tely after, NA-C walked over to R11's head and fed her a bite by after, NA-C walked back to wn hair as she sat down, and rerware. NA-C did not performing these observations.  NA-D touched her face mask and then fed R9 using the 4 a.m. NA-D walked over to im a cup of coffee and tray from the table. As she ay in the metal container, she is on the metal tray onto the icked up the cups, she walked ay room where she handed e and used the TV remote. Irank from the cup. NA-D did hygiene during these  NA-C, after picking up meal a glass which R9 immediately R9 finished drinking, NA-C the area with a clothing ought the clothing protector to ndry bin and touched the bin lid lift it. After, NA-C touched her another resident's clothing ed the remaining trays in the p.m. NA-C placed a transfer ansferred him to a recliner. | F 8                                | ,  |        |                            |
|                          | to be absent from<br>only accessible sa<br>the dining room, ha  | n hand sanitizer was observed<br>the dining room tables. The<br>nitizer station was just inside<br>anging on the wall which would<br>f to get up through out the meal<br>tly.  |                                    |  |        |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING   |                     |  | COMPLETED |                            |  |
|--|---|---|---------------------|--|-----------|----------------------------|--|
|  |   | 245438  | B. WING _           |  | 11        | C<br>1 <b>/18/2020</b>     |  |
|  | PROVIDER OR SUPPLIER  |   |                     | STREET ADDRESS, CITY, STATE, ZIP COD<br>1717 UNIVERSITY DRIVE SOUTHEAST<br>SAINT CLOUD, MN 56304 | E         | 11012020                   |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)      | OULD BE   | (X5)<br>COMPLETION<br>DATE |  |
| F 880  | stated hand hygier residents and before NA-C acknowledge hygiene during observed prior to assisting Fistated not perform required times risks. When interviewed NA-D stated hand and after resident resident to eat, "be everything." NA-D washed her hands in the dining room performed hand hythe remainder of the stated not perform required times risk or an infection."  During interview of DON stated she we performed after ar resident. The DOI following infection | age 85 In 11/18/20, at 1:34 p.m. NA-C ne was required before feeding ore and after touching them. ed she did not perform hand servation from 1:18 p.m. to 210 into the recliner. NA-C ing hand hygiene at the red getting the residents "sick."  on 11/18/20, at 1:40 p.m. hygiene was required before cares, before assisting a refore anything, " and, "after acknowledged she had a prior to starting feeding assist however, denied having regiene after that or throughout the observation period. NA-C ing hand hygiene at the red, "definitely them getting sick on 11/28/20, at 2:08 p.m. the rould expect hand hygiene to be any physical contact with a N explained if staff were not control guidelines there was a to "spread infection to residents" | F 88                | 0  |           |                            |  |
|  | residents were sea<br>memory care dinir<br>six feet of at least   | NG: n on 11/18/20, at 1:08 p.m. 12 ated around 6 tables in the ng room. Each table was within one other adjacent table. All emory care dining room (R8.   |                     |  |           |                            |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING   |                     |  | (X3) DATE SURVEY COMPLETED C |                            |
|--|--|---|---------------------|--|------------------------------|----------------------------|
|  |  | 245438  | B. WING             |  | 11                           | /18/2020                   |
|  | PROVIDER OR SUPPLIER   | AB CENTER   | ,                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1717 UNIVERSITY DRIVE SOUTHEAST<br>SAINT CLOUD, MN 56304        |                              |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>( (EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE                      | (X5)<br>COMPLETION<br>DATE |
| F 880  | R9, R10, R11, R12<br>R18) except for R1<br>approximately 3 fethe only resident of<br>distanced at 6 feet<br>room floors or table<br>indicators of place<br>social distancing w<br>no indicators to directly<br>On 11/28/20, at 1:<br>enter the dining roo<br>R8, where NA-C w<br>NA-D and R9, and<br>eating. NA-D conting  | R, R13, R14, R15, R16, R17, 9 were observed to be et from each other. R19 was observed to be socially during meal time. The dining es did not show visible ment reminders to ensure as maintained and there were ect staff of resident placement. It is p.m. NA-C was observed to om and sat on the right side of as positioned across from started to assist R8 with nued to assist R9 with eating.  | F8                  | 80   |                              |                            |
|  | distancing guidelin typically sat in the showever, voiced we spread the resident attempted to place during the noon me spread out. NA-C were not socially dependent of the second of the | of communal dining social es. NA-C explained residents same spot each meal; the COVID-19 the staff try to ts out. NA-C denied she residents at different spots eal or encouraged them to acknowledged the residents stanced during the noon meal; d she did not feel there was aintain social distancing for all the dining room.  on 11/18/20, at 1:40 p.m. edge of communal dining uidelines. NA-D explained, social distance but it is very D explained the residents who esistance were the hardest distances as "we have to feed ime" and "we do not always" |                     |  |                              |                            |

|                          | T OF DEFICIENCIES<br>DF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                 | IPLE CONSTRUCTION  IG   |        | ATE SURVEY<br>DMPLETED     |
|--------------------------|--|--|---------------------|---|--------|----------------------------|
|                          |  | 245438   | B. WING _           |   | 1      | C<br><b>1/18/2020</b>      |
|                          | PROVIDER OR SUPPLIER   |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1717 UNIVERSITY DRIVE SOUTHEAST<br>SAINT CLOUD, MN 56304       |        | 1710/2020                  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPI<br>DEFICIENCY) | ULD BE | (X5)<br>COMPLETION<br>DATE |
| F 880                    | have three aides be acknowledged the distanced during the had attempted to provide spots during the macknowledged the distanced during the macknowledged the macknowledged out.  During interview or registered nurse (Frommunal dining some stated had not some stated he did not some stated had not make the macknowledged pobservation, RN-C resident had not make the macknowledged pobservation of the macknowledged pobservation of the macknowledged pobservation of the macknowledged pobserved the dining the meals. The observed the dining some time and have garding staff condistancing. The pobserved the dining some time and have garding staff condistancing. The pobserved the dining some time and have social however, she voice the dining social however, she voice states and chair help ensure social however, she voice the dining staff condistancing. The pobserved the dining some time and have social however, she voice the dining staff condistancing. The pobserved the dining some time and have social however, she voice the distancing of the pobserved the dining some time and have social however, she voice the distancing of the pobserved the dining some time and have social however, she voice the distancing of the pobserved the dining some time and the pobserved | ack here." NA-D residents were not socially ne noon meal and denied she place residents at different eal or encouraged them to  n 11/18/20, at 1:50 p.m. RN)-C stated knowledge of social distancing guidelines. ad entered the dining room that afternoon to observe for sues during the noon meal and ee concerns at that time. n able to recall which residents e dining room or where they g RN-C's observation. After rebally updated on the pattern during the 1:08 p.m. acknowledged all but one naintained social distancing  eyor's continued observational et RN-C entering the dining |                     | 30  |        |                            |

| · ,                      |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MUL <sup>-</sup><br>A. BUILDI | FIPLE CONSTRUCTION NG  |  | (X3) DATE SURVEY COMPLETED C |  |  |
|--------------------------|--|--|------------------------------------|--|--|------------------------------|--|--|
|                          |  | 245438   | B. WING                            |  |  | 11/18/2020                   |  |  |
|                          | PROVIDER OR SUPPLIER   | B CENTER   |                                    | STREET ADDRESS, CITY, S<br>1717 UNIVERSITY DRIVE<br>SAINT CLOUD, MN 56 | SOUTHEAST  |                              |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                | ( (EACH CORRECT CROSS-REFERENC   | LAN OF CORRECTION<br>IVE ACTION SHOULD BE<br>ED TO THE APPROPRIA'<br>FICIENCY) |                              |  |  |
| F 880                    | have been taken to<br>the dining room for<br>"We have talked at<br>staff were not follow<br>guidelines there wa<br>"spread infection to  | ensure social distancing in meals; however, she stated, pout it." The DON explained if ving infection control as a potential for them to residents and staff."   | F 8                                | 80   |  |                              |  |  |
|                          | revised 3/2/20 iden masks, protective of shields." Further, the following: "PPE is rooms and removal isolation rooms;" glandling items that when entering isolation designated clear leaving a treatment hands after removing the prior to entering treworn in designated large enough to consing the gown and leaving the treatmed directed when applications." | sonal Protective Equipment, tified, "PPE includes gloves, gowns, eye wear, and face he policy identified the equired for entry into isolation I is required prior to leaving oves should be worn when may be contaminated and ation areas; do not wear gloves a areas and remove before area; immediately washing gloves and glove use does a areas; gowns will be applied atment area and should not be clean areas; gowns should be over the clothing of the person I should be removed before ent area. In addition, the policy ying the gown all clothing is I and be secured at the waist |                                    |  |  |                              |  |  |
|                          | instructed hand hyg<br>before applying glo<br>their removal, after<br>were handled, and  | nd Hygiene, revised 9/17/20 giene was to be performed ves or other PPE and after potentially contaminated items after contact with inanimate ediate vicinity of a resident.  |                                    |  |  |                              |  |  |
|                          | A facility policy Clea   | aning and Disinfection of<br>facility areas of   |                                    |  |  |                              |  |  |

|                          | OF DEFICIENCIES OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | , ,                | TIPLE CONSTRUCTION ING   |        | COMI | E SURVEY<br>PLETED         |
|--------------------------|---|---|--------------------|--|--------|------|----------------------------|
|                          |   | 245438  | B. WING            |  |        | 11/1 | C<br>18/2020               |
|                          | PROVIDER OR SUPPLIER  | B CENTER  |                    | STREET ADDRESS, CITY, STATE, ZIP CO<br>1717 UNIVERSITY DRIVE SOUTHEAS<br>SAINT CLOUD, MN 56304 |        | 1 17 | 10/2020                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |  | SHOULD | BE   | (X5)<br>COMPLETION<br>DATE |
| F 880                    | Suspected/Confirm indicated staff were instructions for all opproducts for concer and contact time, e environmental serviclean hands often, glove removal and staff should wear d for all task in the clehandling trash.  A facility COVID-19 identified, "Commu COVID-19 negative only), residents ma social distancing. L based on COVID-1 Further, the policy in the resident staff was a social distancing. | ed COVID-19, dated 6/23/20 et of follow the manufacturer's eleaning and disinfection intration, application method to. Further, the policy directed ices staff and others should including immediately after that environmental services isposable gloves and gowns eaning process, including imited (for error asymptomatic residents yeat in the same room with imitations will be considered 9 infections in the facility." dentified, "Residents should part if in communal areas." | F8                 | 80   |        |      |                            |



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 7, 2021

Administrator Talahi Nursing And Rehab Center 1717 University Drive Southeast Saint Cloud, MN 56304

Re: Reinspection Results

Event ID: 8TR512

Dear Administrator:

On December 31, 2020 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 31, 2020. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Douglas Larson, Enforcement Specialist

Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit

DWELDS SLAPROW

Health Regulation Division

Telephone: 651-201-4118 Fax: 651-215-9697

Email: doug.larson@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered December 11, 2020

Administrator Talahi Nursing And Rehab Center 1717 University Drive Southeast Saint Cloud, MN 56304

Re: State Nursing Home Licensing Orders

Event ID: 8TR511

#### Dear Administrator:

The above facility was surveyed on November 13, 2020 through November 18, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html</a>. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

Talahi Nursing And Rehab Center December 11, 2020 Page 2

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Susie Haben, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us

Office: (320) 223-7356 Mobile: (651) 230-2334

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

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

Please feel free to call me with any questions.

Sincerely,

Jovens Stapson

Douglas Larson, Enforcement Specialist Minnesota Department of Health

Licensing and Certification Program

Talahi Nursing And Rehab Center December 11, 2020 Page 3

Program Assurance Unit Health Regulation Division

Telephone: 651-201-4118 Fax: 651-215-9697

Email: doug.larson@state.mn.us

cc: Licensing and Certification File

(X6) DATE

Minnesota Department of Health

|                          | NT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPP<br>IDENTIFICATION I   |  | ` ′                      | E CONSTRUCTION  | (X3) DATE<br>COMF | SURVEY<br>PLETED         |
|--------------------------|---|--|--|--------------------------|---|-------------------|--------------------------|
|                          |   |  |  | A. BOILDING.             |   | R                 | -C                       |
|                          |   | 00614  |  | B. WING                  |   |                   | 31/2020                  |
| NAME OF I                | PROVIDER OR SUPPLIER  |  |  |                          | STATE, ZIP CODE   |                   |                          |
| TALAHI                   | NURSING AND REHA  | AB CENTER  |  | /ERSITY DR<br>OUD, MN 50 | IVE SOUTHEAST<br>6304   |                   |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCY<br>Y MUST BE PRECEDED I<br>SC IDENTIFYING INFOR  | BY FULL  | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF CORRI<br>(EACH CORRECTIVE ACTION SI<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY) | HOULD BE          | (X5)<br>COMPLETE<br>DATE |
| {2 000}                  | Initial Comments  |  |  | {2 000}                  |   |                   |                          |
|                          | ****ATTE  | NTION*****   |  |                          |   |                   |                          |
|                          | NH LICENSING CORRECTION ORDER   |  |  |                          |   |                   |                          |
|                          | In accordance with 144A.10, this correpursuant to a surve found that the deficiency found that the deficiency for the deficiency for the Minnesota Deputermination of which is a schedule of the Minnesota Deputermination of which is a requirements of the number and MN Rule When a rule contains comply with any of lack of compliance re-inspection with a result in the assess that was violated decorrected. | ction order has been by. If, upon reinspection or deficiencing or deficiencing of the certed, a fine for each be assessed in accompliance with all the rule provided at the litems will be considered by the items will be con | en issued ction, it is es cited ch violation cordance by rule of as been as been as tag ed below. Eallure to considered ce upon rt rule will if the item |                          |   |                   |                          |
|                          | You may request a that may result from orders provided that the Department with notice of assessment.   | n non-compliance wat a written request<br>hin 15 days of rece  | with these<br>is made to<br>ipt of a   |                          |   |                   |                          |
|                          | INITIAL COMMENTON 12/31/20, an or surveyors of the Mi (MDH) to follow up for State Licensure exited on 11/18/20 found substantiated survey were review  | nsite revisit was cor<br>nnesota Departme<br>on correction orde<br>from an abbreviate<br>The complaint inv<br>d at the time of the   | nt of Health<br>rs issued<br>ed survey<br>estigation(s)<br>licensing   |                          |   |                   |                          |

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

**Electronically Signed** 01/07/21

TITLE

Minnesota Department of Health

|                          | OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                         | LE CONSTRUCTION   | (X3) DATE<br>COMPI |                          |
|--------------------------|---|--|-----------------------------|---|--------------------|--------------------------|
|                          |   | 00044  | B. WING                     |   | R-                 |                          |
|                          |   | 00614  | B. WING                     |   | 12/3               | 1/2020                   |
| NAME OF                  | PROVIDER OR SUPPLIER  |  |                             | STATE, ZIP CODE   |                    |                          |
| TALAHI                   | NURSING AND REHA  | R CENTER   | NIVERSITY DR<br>CLOUD, MN 5 | RIVE SOUTHEAST<br>6304  |                    |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF CORRI<br>(EACH CORRECTIVE ACTION SI<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY) | HOULD BE           | (X5)<br>COMPLETE<br>DATE |
| {2 000}                  | Continued From pa   | ge 1   | {2 000}                     |   |                    |                          |
|                          | H5438095C and all found to be corrected                             | cited licensing orders were ed.  |                             |   |                    |                          |
|                          | signature is not req<br>page of the CMS-29<br>correction is require | ed in ePOC and therefore a<br>uired at the bottom of the firs<br>567 form. Although no plan o<br>ed, it is required that the facili<br>ot of the electronic document | f<br>ty                     |   |                    |                          |
|                          |   |  |                             |   |                    |                          |
|                          |   |  |                             |   |                    |                          |
|                          |   |  |                             |   |                    |                          |
|                          |   |  |                             |   |                    |                          |
|                          |   |  |                             |   |                    |                          |

Minnesota Department of Health

(X6) DATE

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:  |   |                           | (X3) DATE SURVEY<br>COMPLETED  |        |                          |
|---|--|---|---|---------------------------|--|--------|--------------------------|
|   |  |   |   |                           |  |        |                          |
|   |  | 00614   |   | B. WING                   |  | 11/1   | 8/2020                   |
| NAME OF   | PROVIDER OR SUPPLIER   |   |   |                           | STATE, ZIP CODE  |        |                          |
| TALAHI  | NURSING AND REHA   | B CENTER  | _   | /ERSITY DR<br>OUD, MN  50 | IVE SOUTHEAST<br>6304  |        |                          |
| (X4) ID<br>PREFIX<br>TAG  |  | TEMENT OF DEFICION  MUST BE PRECEDO  SC IDENTIFYING INF   | ENCIES<br>ED BY FULL  | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | ILD BE | (X5)<br>COMPLETE<br>DATE |
| 2 000   | Initial Comments   |   |   | 2 000                     |  |        |                          |
|   | ****ATTE   | NTION*****  |   |                           |  |        |                          |
|   | NH LICENSING CORRECTION ORDER  |   |   |                           |  |        |                          |
|   | In accordance with 144A.10, this correct pursuant to a surve found that the defic herein are not corrected shall with a schedule of the Minnesota Depart   | ction order has by. If, upon reins iency or deficien ected, a fine for the assessed in a fines promulgate                           | peen issued spection, it is noies cited each violation accordance ed by rule of             |                           |  |        |                          |
|   | Determination of what corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess that was violated ducorrected. | compliance with rule provided a alle number indicens several items the items will be Lack of compliny item of multiment of a fine e | all t the tag ated below. f, failure to considered ance upon part rule will ven if the item |                           |  |        |                          |
|   | You may request a that may result from orders provided that the Department with notice of assessme   | n non-compliand<br>t a written reque<br>hin 15 days of re   | ee with these est is made to eceipt of a  |                           |  |        |                          |
|   | INITIAL COMMENT<br>On 11/13/20 to 11/2<br>by surveyors from t<br>Health (MDH) to de<br>licensure in conjuct<br>investigation(s): H5  | 18/20, a survey the Minnesota Determine compliation with complai  | epartment of<br>ance for state  |                           |  |        |                          |
|   | As a result, the follo   | wing correction   | orders are  |                           |  |        |                          |

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

TITLE

**Electronically Signed** 12/18/20

Minnesota Department of Health

|                          |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | 1 ' '                    | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                          |
|--------------------------|--|---|--------------------------|--|-------------------------------|--------------------------|
| ANDFLAN                  | OF CONNECTION  | IDENTIFICATION NOWIBER.   | A. BUILDING:             | <del></del>  |                               |                          |
|                          |  | 00614   | B. WING                  |  | 11/1                          | 8/2020                   |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET AD   | DRESS, CITY, S           | STATE, ZIP CODE  |                               |                          |
| TALAHI                   | NURSING AND REHA   | AR CENTER   | VERSITY DR<br>OUD, MN 50 | IVE SOUTHEAST<br>6304  |                               |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE                         | (X5)<br>COMPLETE<br>DATE |
| 2 000                    | correction that you and identify the dat Minnesota Department the State Licensing federal software. The assigned to Minnesota Department of the findings which are statute after the Suggested Time period for Co-You have agreed to receipt of State lice the Minnesota Dep Informational Buller http://www.health.sobul.htm The State delineated on the after the word "corrected on the state of the word "corrected prior to empletion date, the corrected prior to emplet the date of | cate your electronic plan of have reviewed these order, e when they will be corrected.  The ent of Health is documenting and numbers have been sota state statutes/rules for the assigned tag number eff column entitled "ID Prefix atute/rule out of compliance is the "To Comply" portion of the state of the inviolation of the state attement, "This Rule is not met collowing the surveyors findings are in violation of the state attement, "This Rule is not met collowing the surveyors findings are in violation of the state attement of Health the in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf the licensing orders are attached Minnesota and inthe orders being submitted to although no plan of correction at Statutes/Rules, please rected" in the box available for a indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the ment of Health.  ARD THE HEADING OF THE | 2 000                    |  |                               |                          |
|                          |  | N WHICH STATES,<br>NN OF CORRECTION." THIS  |                          |  |                               |                          |

Minnesota Department of Health

STATE FORM 8TR511 If continuation sheet 2 of 53

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X1) PROVIDER/SUPPLIER/CLIA   | (X2) MULTIPLE CONSTRUCTION (X: A. BUILDING: |  |      | (X3) DATE SURVEY<br>COMPLETED |  |
|--|---|---|---|--|------|-------------------------------|--|
|  |   |   |   |  | 1    | С                             |  |
|  |   | 00614   | B. WING                                     |  | 11/1 | 8/2020                        |  |
| NAME OF  | PROVIDER OR SUPPLIER  |   |   | STATE, ZIP CODE  |      |                               |  |
| TALAHI   | NURSING AND REHA  | AB CENTER   | /ERSITY DR<br>OUD, MN  50                   | IVE SOUTHEAST<br>6304  |      |                               |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  |   | ID<br>PREFIX<br>TAG                         | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE | D BE | (X5)<br>COMPLETE<br>DATE      |  |
| 2 000  | Continued From page 2  APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.  |   | 2 000                                       |  |      |                               |  |
| 2 830  | MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General  Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. |   | 2 830                                       |  |      | 12/23/20                      |  |
|  | by: Based on interview facility failed to coo physician orders ar psychiatric physicia health needs were (R2) reviewed who and subsequently medications held for Findings include:  R2's quarterly MDS  | and document review, the rdinate care and obtain ad/or guidance from an outside an group to ensure mental addressed for 1 of 1 residents refused laboratory monitoring and their ordered antipsychotic or an extended period of time. |   | Corrected  |      |                               |  |

Minnesota Department of Health

STATE FORM 8TR511 If continuation sheet 3 of 53

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:   |  |  | X3) DATE SURVEY<br>COMPLETED   |                          |
|--|--|---|--|--|--------------------------------|--------------------------|
|  |  | 00614   | B. WING  |  |                                | C<br><b>18/2020</b>      |
| TALAHI NURSING AND REHAB CENTER 1717 UNI   |  |   | DDRESS, CITY, S<br>IVERSITY DRI<br>LOUD, MN 56 | VE SOUTHEAST   |                                |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                            | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| 2 830  | person's ability to the and moderate cognition demonstrated no have rejection of care be supervision with an his room.  R2's care plan, date communication def "Anticipate and medication related listed several intervigoal including, but in the medication (s) a pharmacist and phyreductions, and modeffects including agenerated and threw the medication and drawer reviewed and on 10/19/20, a propharmacy came to medication and drawer fused and threw the note outlined, '[sic] medication sin The note identified updated.  On 10/22/20 (three identified R2 had refund the responding Generogress Note, date | ge 3  nink, feel, and behave clearly) itive impairment. Further, R2 allucinations, delusions or haviors, and required only inbulation in the corridor and  ed 10/5/20, identified R2 had a icit and directed staff to, et needs." Further, R2 was ne antipsychotic medication being free of psychotropic complications. The care plan entions to help R2 meet this not limited to, administering s ordered, consulting with the visician on potential dose nitoring for adverse side itation and restlessness.  d, including progress notes, identified the following:  gress note identified the deliver R2's antipsychotic w routine laboratory work. R2 nis coffee at the employee. Pharmacy unable to delivery ce resident refused lab draw." registered nurse (RN)-A was  days later), a progress note of attempt to obtain the lab(s) are scription could be filled. A evive (Physician Group) ed 10/22/20, identified R2's titioner (NP)-B was updated |  |  |                                |                          |

Minnesota Department of Health

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Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION A. BUILDING:  |   |  | (X3) DATE SURVEY<br>COMPLETED  |                                 |                          |
|---|--|--|---|--|--|---------------------------------|--------------------------|
|   |  | 00614  |   | B. WING                                  |  |                                 | C<br><b>18/2020</b>      |
| TALAHI NURSING AND REHAB CENTER 1717 UNIV   |  |  |   | STATE, ZIP CODE<br>IVE SOUTHEAST<br>5304 |  |                                 |                          |
| (X4) ID<br>PREFIX<br>TAG  |  | TEMENT OF DEFIC<br>MUST BE PRECED<br>SC IDENTIFYING IN   | ED BY FULL  | ID<br>PREFIX<br>TAG                      | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACT)<br>CROSS-REFERENCED TO T<br>DEFICIENC' | ION SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| 2 830   | Continued From particles on R2's refusal to a 10/19/20, so no me administration as a consuming 500 mg note outlined NP-B tell [nursing home] psychiatrist is the orange of the corded which ide on R2's refusal to a clozapine. The note nystrom appointme possible]. Nystrom made for 11/12/20.  On 10/31/20, a progrand sat by the 'Weshe needed anything began yelling at wriminutes a [NA] can looked at her and y [three times]." R2 w good portion" of the walking around, incoming a considerable of the statempted by the statempted by the statempted by the statempted as being, recorded as being,  | allow the laborate dication was averesult. R2 was of clozapine expended, "Pleato keep trying wardering provide e-entry progress not field NP-B hardllow laboratory e continued, "NF and made ASAP [psychiatry clinisms of the down the hald relled 'you fucking as recorded as a day outside of cluding standing buttons in attemny evidence of irrest to calm or reviors. | vailable for listed as veryday. The ease call and with labs. His r I believe."  Inote was d been updated draw(s) for his P[-B] wanted [as soon as ic] appointment tified R2 came s questioned if ut then " After a few llway and heng nigger' X3 is spending "a his room by the front pt to open it. Interventions edirect R2 fied R2 was | 2 830                                    |  |                                 |                          |
|   | having hallucination at him and resident you' drew his arm going to punch nurs is very abnormal be nurse sat down new which was effective note identified the limited the limited at t | ns during shift Iflicked nurse on back as if actions. The note contained for resident to R2 and talks in calming him   | [nurse] waved off, said 'fuck ing he was ontinued, "This lent." The ked with him odown. The   |  |  |                                 |                          |

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Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  |  |                     |  |       | TE SURVEY                |  |
|--|--|---------------------|--|-------|--------------------------|--|
|  |  |                     |  | С     |                          |  |
|  | 00614  | B. WING             |  | 11/1  | 8/2020                   |  |
| NAME OF PROVIDER OR SUPPLIER   | STREET AD  | DRESS, CITY, S      | STATE, ZIP CODE  |       |                          |  |
| TALAHI NURSING AND REHAB   | CENTER 1717 UNIV   | ERSITY DR           | IVE SOUTHEAST  |       |                          |  |
| TALATI NONONO AND ILLIAD   | SAINT CL   | OUD, MN 50          | 6304   |       |                          |  |
| PREFIX (EACH DEFICIENCY M  | EMENT OF DEFICIENCIES<br>JUST BE PRECEDED BY FULL<br>CIDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUI<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE | (X5)<br>COMPLETE<br>DATE |  |
| 2 830 Continued From page  | e 5  | 2 830               |  |       |                          |  |
| draw R2's lab(s) on the what caused resident provided education of draw, however, the new observed as restles aggression or agitation approached nurse standard replied 'That hates me, and that I sidentified the nurse perfective and start crying. Genew as contacted due to restlessness and an etwice a day as-needed (3) day period " un resolved." This was note recorded, " age effectiveness." R2's Phone Encounter note the nursing home had reporting R2 " is exagitation, aggression was receiving Clozap not been sent as they be completed, though labs staff are concountered along with, 'follow-up with patient provider] this week reward facility through around facility through a cause of the provided R2 waround facility through a cause of the provided R2 waround facility through a cause of the provided R2 waround facility through a cause of the provided R2 waround facility through a cause of the provided R2 waround facility through the provided R2 ware R | the prior shift which " is to become upset." R2 was in the importance of the lab ote outlined R2 continued to ess but without physical on. The note continued, "[R2] ating 'I am hearing voices.' e voices were telling him and in o one likes me, everyone should just die." The note rovided comfort to R2 whome nurse and become upset evive (physician service) or R2's continued order for clonazepam 0.5 mg ed was provided for a three til cozapine issue was administered to R2 and the opeared to have corresponding Genevive te, dated 10/31/20, identified d contacted the service experiencing increased and hallucinations patient oine [sic], though a script has y are waiting for lab work to in patient continues to refuse erned for his agitation." The ler for clonazepam 0.5 mg ed for three days was "Nursing staff are to | 2 830               |  |       |                          |  |

Minnesota Department of Health

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Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:  |                          |  | (X3) DATE SURVEY<br>COMPLETED |                          |
|--|---|---|--------------------------|--|-------------------------------|--------------------------|
|  |   | 00614   | B. WING                  |  | <b>I</b>                      | C<br><b>18/2020</b>      |
| NAME OF  | PROVIDER OR SUPPLIER  | STREET AD   | DRESS, CITY, S           | STATE, ZIP CODE  |                               |                          |
| TALAHI   | NURSING AND REHA  | R CENTER  | /ERSITY DR<br>OUD, MN 50 | IVE SOUTHEAST<br>6304  |                               |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE API<br>DEFICIENCY) | IOULD BE                      | (X5)<br>COMPLETE<br>DATE |
| 2 830  | want! I'm over 18!' reassurance provid staff member at fro staff member when threw desk supplies outlined education a provided, however, more angry as staff provided time and sand " appeared to refuse medications.  On 11/2/20, a progrentered R2's room and was laying in break R2 proceeded to coprovided R2 his ora his right hand arour then took his hand. The note identified appropriate to grableft the room.  On 11/2/20, a subsidentified, "New bell Behavior addressed.  On 11/3/20, a progremere received from emergency room (E11/3/20, identified F(G)-A and the nurse laboratory draw corpresent. The note refuck you, you ain't picked up an orang his guardian." NP-Econtinued inability trended. | Emotional support and ed. Resident then approached nt desk. Became upset with unable to get cigarettes and across lobby." The note and encouragement was R2 " Becomes more and re-approach." R2 was then space to express his feelings o calm down but continues to | 2 830                    |  |                               |                          |

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| Minnesota Department of Health |  |  |                |   |           |          |
|--------------------------------|--|--|----------------|---|-----------|----------|
|                                | NT OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA                                  | (X2) MULTIPL   | E CONSTRUCTION                                | (X3) DATE |          |
| AND PLAN                       | OF CORRECTION  | IDENTIFICATION NUMBER:                                       | A. BUILDING:   |   | COMP      | LETED    |
|                                |  |  |                |   |           | :        |
|                                |  | 00614  | B. WING        |   |           | 8/2020   |
|                                |  |  | ı              |   |           | 0,2020   |
| NAME OF I                      | PROVIDER OR SUPPLIER   | STREET AD  | DRESS, CITY, S | STATE, ZIP CODE                               |           |          |
| TAI AUI                        | NURSING AND REHA   | R CENTER 1717 UNIV   | ERSITY DR      | IVE SOUTHEAST                                 |           |          |
| IALAIII                        | NONSING AND INCINA   | SAINT CL   | OUD, MN 50     | 6304  |           |          |
| (X4) ID                        | SUMMARY STA  | TEMENT OF DEFICIENCIES                                       | ID             | PROVIDER'S PLAN OF CORRECTION                 | ON        | (X5)     |
| PRÉFIX                         |  | MUST BE PRECEDED BY FULL                                     | PREFIX         | (EACH CORRECTIVE ACTION SHOUL                 |           | COMPLETE |
| TAG                            | REGULATORY OR L  | SC IDENTIFYING INFORMATION)                                  | TAG            | CROSS-REFERENCED TO THE APPROI<br>DEFICIENCY) | PRIATE    | DATE     |
|                                |  |  |                |   |           |          |
| 2 830                          | Continued From pa  | ge 7   | 2 830          |   |           |          |
|                                | to be cent in to the   | hoonital for further evaluation "                            |                |   |           |          |
|                                |  | hospital for further evaluation." hospital ER via ambulance. |                |   |           |          |
|                                |  | Genevive Progress Note,                                      |                |   |           |          |
|                                |  | tified NP-B was contacted as                                 |                |   |           |          |
|                                |  | ut his ordered clozapine for                                 |                |   |           |          |
|                                |  | as refusing to allow laboratory                              |                |   |           |          |
|                                |  | entified, "Behaviors increased                               |                |   |           |          |
|                                |  | med." R2's guardian was                                      |                |   |           |          |
|                                |  | lly was able to get R2 to have                               |                |   |           |          |
|                                |  | nursing home staff were                                      |                |   |           |          |
|                                |  | r the needed lab draw(s). An                                 |                |   |           |          |
|                                |  | ated by NP-B which identified,                               |                |   |           |          |
|                                |  | age this, his psych provider                                 |                |   |           |          |
|                                |  | calling site nurse back, site                                |                |   |           |          |
|                                |  | orders for labs no longer                                    |                |   |           |          |
|                                | needed, now need   | okay to send to ED [R2]                                      |                |   |           |          |
|                                | threw a traffic cone   | at his guardian. Guardian                                    |                |   |           |          |
|                                |  | never seen [R2] as agitated                                  |                |   |           |          |
|                                | and aggressive as I  | he is right now, wants sent into                             |                |   |           |          |
|                                | ED. Facility staff als   | so aren't able to manage                                     |                |   |           |          |
|                                |  | ne." A telephone order was                                   |                |   |           |          |
|                                | provided to send R   | 2 to the ED.   |                |   |           |          |
|                                |  |  |                |   |           |          |
|                                |  | otes, dated 11/3/20, identified                              |                |   |           |          |
|                                | •  | ED with a chief complaint                                    |                |   |           |          |
|                                |  | ve behavior." R2 reported he                                 |                |   |           |          |
|                                |  | re then voicing he resided at                                |                |   |           |          |
|                                |  | and also was recorded as                                     |                |   |           |          |
|                                |  | ne at one of the nurses. R2                                  |                |   |           |          |
|                                | voiced he was unaware why he had been sent to<br>the ED, but did endorse having suicidal ideation. |  |                |   |           |          |
|                                |  |  |                |   |           |          |
|                                | R2's needed laboratory draw(s) were completed and a behavioral consultation was completed and      |  |                |   |           |          |
|                                |  | charge back to the nursing                                   |                |   |           |          |
|                                |  | orded as, " he is now willing                                |                |   |           |          |
|                                |  | redications." Further, R2's                                  |                |   |           |          |
|                                |  | progress note, dated 11/3/20,                                |                |   |           |          |
|                                |  | ed not taking his medications                                |                |   |           |          |
|                                |  | eel "stressed out." R2 voiced                                |                |   |           |          |
|                                |  | he nursing home and " be                                     |                |   |           |          |

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| Minnesota Department of Health |   |  |                |   |           |                  |
|--------------------------------|---|--|----------------|---|-----------|------------------|
|                                | NT OF DEFICIENCIES                                | (X1) PROVIDER/SUPPLIER/CLIA                      | (X2) MULTIPL   | E CONSTRUCTION  | (X3) DATE |                  |
| AND PLAN                       | OF CORRECTION                                     | IDENTIFICATION NUMBER:                           | A. BUILDING:   |   | COMP      | LETED            |
|                                |   |  |                |   |           |                  |
|                                |   | 00644  | B. WING        |   |           |                  |
|                                |   | 00614  | B. W. C        |   | 11/1      | 8/2020           |
| NAME OF I                      | PROVIDER OR SUPPLIER                              | STREET AD  | DRESS, CITY, S | STATE, ZIP CODE   |           |                  |
|                                |   | 1717 UNI\  | ERSITY DR      | IVE SOUTHEAST   |           |                  |
| TALAHI                         | NURSING AND REHA                                  | BCENTER  | OUD, MN 50     |   |           |                  |
|                                |   |  |                |   |           |                  |
| (X4) ID<br>PREFIX              |   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL | ID<br>PREFIX   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL |           | (X5)<br>COMPLETE |
| TAG                            |   | SC IDENTIFYING INFORMATION)                      | TAG            | CROSS-REFERENCED TO THE APPROI                              |           | DATE             |
|                                |   | ,  | .,,,           | DEFICIENCY)   |           |                  |
|                                | <del>-</del>                                      |  |                |   |           |                  |
| 2 830                          | Continued From pa                                 | ge 8   | 2 830          |   |           |                  |
|                                | on my best behavio                                | or and I'll take my medicine."                   |                |   |           |                  |
|                                |   | nd hallucinations to hurt                        |                |   |           |                  |
|                                |   | ut acknowledged having visual                    |                |   |           |                  |
|                                |   | nes. Further, R2's clinical                      |                |   |           |                  |
|                                |   | nich identified highly impulsive                 |                |   |           |                  |
|                                |   | navior(s) towards others. R2                     |                |   |           |                  |
|                                |   |  |                |   |           |                  |
|                                | was cleared to retu                               | rn to the nursing home.                          |                |   |           |                  |
|                                | On 11/1/20 a progr                                | rose note identified D2                          |                |   |           |                  |
|                                |   | ress note identified R2                          |                |   |           |                  |
|                                |   | R and had several labs,                          |                |   |           |                  |
|                                |   | is completed. The results were                   |                |   |           |                  |
|                                |   | der infection and no new                         |                |   |           |                  |
|                                |   | ment orders were provided.                       |                |   |           |                  |
|                                |   | d, "He is to see [nurse                          |                |   |           |                  |
|                                | practitioner] in 2 da                             | ys."   |                |   |           |                  |
|                                |   |  |                |   |           |                  |
|                                |   | equent progress note                             |                |   |           |                  |
|                                |   | nacy had been updated on the                     |                |   |           |                  |
|                                |   | ry draws, and R2 " needed                        |                |   |           |                  |
|                                |   | medication as soon as                            |                |   |           |                  |
|                                |   | macist voiced they would                         |                |   |           |                  |
|                                |   | to review the laboratory                         |                |   |           |                  |
|                                |   | ontact the nursing home. The                     |                |   |           |                  |
|                                | note concluded, "W                                | riter is awaiting call back from                 |                |   |           |                  |
|                                | pharmacy." Further                                | , an additional note, dated                      |                |   |           |                  |
|                                |   | he pharmacy was again                            |                |   |           |                  |
|                                | contacted. The pha                                | rmacist voiced they needed                       |                |   |           |                  |
|                                | more information or                               | n how many days R2 had                           |                |   |           |                  |
|                                |   | ozapine; which the nursing                       |                |   |           |                  |
|                                |   | ad been "two weeks since his                     |                |   |           |                  |
|                                |   | " The pharmacist then                            |                |   |           |                  |
|                                |   | eded to speak with the provider                  |                |   |           |                  |
|                                | who prescribed the medication to see if it needed |  |                |   |           |                  |
|                                |   | en the length of time R2 had                     |                |   |           |                  |
|                                |   | ation. The pharmacist voiced a                   |                |   |           |                  |
|                                |   | left for the provider, and the                   |                |   |           |                  |
|                                |   | riter is awaiting a respond fro                  |                |   |           |                  |
|                                |   | The is awaiting a respond ito                    |                |   |           |                  |
|                                | pharmacist"                                       |  |                |   |           |                  |
|                                | On 11/6/20, at 1:38                               | a.m. a progress note                             |                |   |           |                  |

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|                          | NT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLI<br>A. BUILDING: | E CONSTRUCTION  | (X3) DATE<br>COMF | SURVEY<br>PLETED         |
|--------------------------|--|--|-------------------------------|---|-------------------|--------------------------|
|                          |  | 00614  | B. WING                       |   |                   | C<br>1 <b>8/2020</b>     |
|                          | PROVIDER OR SUPPLIER  NURSING AND REHA   | B CENTER 1717 UNIV   |                               | TATE, ZIP CODE VE SOUTHEAST 3304  |                   |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG           | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | ULD BE            | (X5)<br>COMPLETE<br>DATE |
| 2 830                    | identified R2 sexual and was removed for R2's Medication Addated 10/2020 to 12 physician ordered in subsequent adminitives listed for clozal everyday; which has the medication was consumed by R2 utility 11/5/20, the MAR is doses of the medical numerous entries of via legend as, "Medical record evidence R2 escalar communicated to Rights physician orders or subsequence of the medical record evidence R2 escalar communicated to Rights in the medical record evidence R2 escalar communicated to Rights in the medical record evidence R2 escalar communicated to Rights in the medical record evidence R2 escalar communicated to Rights in the medical record evidence R2 escalar communicated to Rights in the medical record evidence R2 escalar communicated to Rights in the medical record evidence R2 escalar communicated to Rights in the medical record evidence R2 escalar communicated to Rights in the medical record evidence R2 escalar communicated to Rights in the medical record evidence R2 escalar communicated to Rights in the medical record evidence R2 escalar communicated to Rights in the medical record evidence R2 escalar communicated to Rights in the medical record evidence R2 escalar communicated to Rights in the medical record evidence R2 escalar communicated to Rights in the medical record evidence R2 escalar communicated to Rights in the medical record evidence R2 escalar communicated to Rights in the medical record evidence R2 escalar communicated to Rights in the medical record evidence R2 escalar communicated to Rights in the medical record evidence R2 escalar communicated to Rights in the medical record evidence R2 escalar communicated to Rights in the medical record evidence R2 escalar communicated to Rights in the medical record evidence R2 escalar communicated to Rights in the medical record evidence R2 escalar communicated to Rights in the medical record evidence R2 escalar communicated evidence R2 evidence R2 evidence R3 evidence R4 eviden | Ily assaulted a female resident rom the facility by the police.  ministration Record (MAR), 1/2020, identified R2's nedications and their stration record(s). An order pine 500 milligrams (mg) d a listed start date of 6/25/20. Is record as being given and ntil 10/20/20. From 10/21/20 to dentified nearly all subsequent ation were not given with f, "18," which was identified I not available from the dating behaviors were 12's psychiatry team for new direction despite him refusing          | 2 830                         |   |                   |                          |
|                          | prescribed antipsych 10/20/20.  On 11/13/20, at 1:0 manager (RN)-A ar (LSW)-A were internursing home after to discharge to a very They described R2 never really identified to the weeks leading female resident on admitted using clozand consistently to 10/19/20, when he monitoring and the prescription. RN-A   | and subsequently having his hotic medication held since  7 p.m. registered nurse and licensed social worker viewed. R2 admitted to the a hospitalization and planned enue of less care when able to as "calm and responsive" and ed him to have behaviors prior g up to the incident involving a 11/5/20. RN-A explained R2 apine for his schizophrenia ok the medication until refused the routine laboratory pharmacist would not fill the explained the cart nurse then se practitioner (NP)-B a couple |                               |   |                   |                          |

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|                          | NT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | , ,                 | E CONSTRUCTION   | (X3) DATE<br>COMP | SURVEY<br>LETED          |
|--------------------------|--|---|---------------------|--|-------------------|--------------------------|
|                          |  |   | 71. BOILDING.       | <del></del>  |                   | ,                        |
|                          |  | 00614   | B. WING             |  | 1                 | 8/2020                   |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET AD   | DRESS, CITY, S      | STATE, ZIP CODE  |                   |                          |
| ΤΔΙ ΔΗΙ                  | NURSING AND REHA   | B CENTER 1717 UNIV  | /ERSITY DR          | IVE SOUTHEAST  |                   |                          |
| IALAIII                  | NOROMO AND REITA   | SAINT CL  | OUD, MN 56          | 5304   |                   |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUI<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE             | (X5)<br>COMPLETE<br>DATE |
| 2 830                    | Continued From pa  | ge 10   | 2 830               |  |                   |                          |
|                          | feel comfortable stare-dosing the cloza appointment with R made for as soon a then attempted to celephone, howeves o she left a messar provided though an again attempted to as, at the time, she immediate danger.  |   |                     |  |                   |                          |
|                          | practitioner (NP)-B someone who was prior to 10/19/20, a aware of any behave being abruptly stop not personally orde the prescriber is recertification as it was medication." The malaboratory values to at times, pharmacia medication until the result of those thing psychiatry team was clozapine. NP-B exalaboratory monitoring provider service was later on 10/22 medication orders wa | 2 p.m. R2's medical nurse was interviewed. R2 was "very reserved" and "quiet" nd NP-B verified she was "not viors" prior to the clozapine ped. NP-B explained she did r or manage R2's clozapine as quired to have a special as "a very dangerous redication required certain be checked periodically and, as would not even release the ese lab(s) were obtained. As a gs, NP-B stated R2's is managing his ordered plained when R2 refused the eng on 10/19/20, their on-call as notified about it a couple very given as she assumed and already been in touch with m and she would have "no ered or did. On 10/31/20, were again notified R2's to be worsening and, at that y dose of clonazepam (a |                     |  |                   |                          |

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|                          |   | E SURVEY<br>PLETED  |   |                             |  |                                   |                          |
|--------------------------|---|---|---|-----------------------------|--|-----------------------------------|--------------------------|
|                          |   | 00614   |   | B. WING                     |  |                                   | C<br><b>18/2020</b>      |
| NAME OF                  | PROVIDER OR SUPPLIER  |   | STREET AD   | DRESS, CITY, S              | STATE, ZIP CODE  | ·                                 |                          |
| TALAHI                   | NURSING AND REHA  | B CENTER  |   | VERSITY DR<br>.OUD, MN   50 | IVE SOUTHEAST<br>6304  |                                   |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIE<br>MUST BE PRECEDE<br>SC IDENTIFYING INF  | ED BY FULL  | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO 1<br>DEFICIENC | ΓΙΟΝ SHOULD BE<br>ΓΗΕ APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| 2 830                    | Continued From part on 11/3/20, NP-B was now being very "two weeks" without NP-B stated this was had not had his clost ordered him to be a nursing home felt the anymore. The ED of laboratory draw(s) and nursing home was clozapine restarted facility on 11/4/20. If aware R2's psychiat notified of his refust draw(s) and subsect voicing that was "under the company of | vas updated aga vaggressive and this antipsychologisthe first time is exapine "for awhile evaluated in the ney couldn't completed the nearly to her know working on getting when he returned NP-B expressed atry team had nearly to allow the laquent holding of infortunate."  In 11/17/20, at 1 (DON) explained a getting his scheel de they did not he shad not be apine, but felt "putil the week just the female reside er expectation was a try draw and sulport of the same day ory draw and sulport of the same day or the same | d had gone for tic medication. She realized he le" and then ED as the trol him ecessary vledge, the ng his ed to the lashe was not ever been boratory his clozapine  11:32 a.m. the dashe had eduled an urses station ave the ecall the exact been getting retty confident" prior to the nt on 11/5/20. The initially beequently  11:32 a.m. the dashe had eduled an urses station ave the ecall the exact been getting retty confident" prior to the nt on 11/5/20. The initially beequently  11:32 a.m. the dashe exact been getting retty confident prior to the nt on 11/5/20. The initially beautiful have he initially be attempted to exist and the 0, where R2 is aulting her. A 11/18/20, and ephone | 2 830                       |  |                                   |                          |

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|                          | NT OF DEFICIENCIES OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA   | , ,                      | E CONSTRUCTION   | (X3) DATE | SURVEY                   |
|--------------------------|--|---|--------------------------|--|-----------|--------------------------|
| 7.1.12 . 27.11           | o. oo.u.2011o.u  |   | A. BUILDING:             |  |           |                          |
|                          |  | 00614   | B. WING                  |  | 11/1      | 3<br>8/2020              |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET AD   | DRESS, CITY, S           | STATE, ZIP CODE  |           |                          |
| TALAHI                   | NURSING AND REHA   | AB CENTER   | /ERSITY DR<br>OUD, MN 50 | IVE SOUTHEAST<br>6304  |           |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE     | (X5)<br>COMPLETE<br>DATE |
| 2 830                    | 12/2/20, at 1:41 p.r verified she helped for the duration of NP-A described R2 often displayed poor health. NP-A stated 10/19/20, when R2 and pharmacy wou clozapine; however time so she was no stated the nursing re-contacted them back as someone should demonstrate symptoms adding I his clozapine for "a arrested. NP-A state escalating behavior had their clinic bees tarted other medicavailable."  A provided Physicia 3/27/20, identified of a under the care of a the nursing home. resident's attending prescribing new the delegate task(s) to desired. The policy guidance on coordinate outside providers wound to the prescribe medications. | m. NP-A was interviewed and oversee his psychiatric care his nursing home admission. 2 as a "very poor historian" who or insight into his own mental d their clinic was notified on refused his laboratory draw old not fill his ordered r, NP-A was on vacation at the ot personally updated. NP-A | 2 830                    |  |           |                          |
|                          | facility failed to ens   | and document review, the ure escalating behaviors were ssed and interventions sure safety and reduce the risk   |                          |  |           |                          |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONS AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING: |  |  |   | E SURVEY<br>PLETED  |   |                                |                          |
|--|--|--|---|---------------------|---|--------------------------------|--------------------------|
|  |  | 00614  |   | B. WING             |   |                                | C<br><b>18/2020</b>      |
|  | PROVIDER OR SUPPLIER  NURSING AND REHA   | B CENTER   | 1717 UNI  |                     | STATE, ZIP CODE  IVE SOUTHEAST 6304   |                                |                          |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STA<br>(EACH DEFICIENC)<br>REGULATORY OR L   |  | DED BY FULL   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| 2 830  | Continued From particles of adverse events for reviewed who demanded aggression and hall stopping their antipresulted in actual particles of assessing contributed to escape sexual assault of an R2's imprisonment.  Findings include:  A submitted state and atted 11/6/20, identification of sexual assaulting another R2 had been found having sexual interstance the police were contributed by the police were contributed by the facility. Further, witnesses to the all assistant (NA)-A, N (LPN)-A and registed on 11/13/20, at 12 guardian (G)-A was had been involved year and explained home in June 2020 therapy after a hos R2's mentation as meds" and outlined well" before 10/19/2 clozapine (an antipstopped abruptly. On this laboratory draw be provided his ord and subsequently havoiced she had new with the demonstral | for 1 of 1 reside constrated increal lucinations after sychotic medical sychosocial harmont and intervel lating behaviors nother resident. The resident. The resident. The resident. The resident. The resident course." The resident course." The resident and remarked re | ased physical r abruptly ation. This rm for R2 when entions and the resulting in ident Report, reported g R2 sexually eport outlined report outlined report outlined report outlined rever a reported g R2 from d several ncluded nursing practical nurse reported several ncluded nursing practical nurse reported several ncluded nursing bilitation a described went off his so doing "quite escribed ation) was R2 had refused ed him to not otic medication behaviors. G-A een R2 to act |                     |   |                                |                          |

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| Millineso         | ita Department of He | aith   | _              |   |           |                  |
|-------------------|----------------------|--|----------------|---|-----------|------------------|
|                   | NT OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA                      | (X2) MULTIPL   | E CONSTRUCTION  | (X3) DATE |                  |
| AND PLAN          | OF CORRECTION        | IDENTIFICATION NUMBER:                           | A. BUILDING:   |   | COMP      | LETED            |
|                   |                      |  |                |   | ے ا       | 、                |
|                   |                      | 00644  | B. WING        |   | 44/4      |                  |
|                   |                      | 00614  |                |   | 11/1      | 8/2020           |
| NAME OF F         | PROVIDER OR SUPPLIER | STREET AD  | DRESS, CITY, S | STATE, ZIP CODE   |           |                  |
|                   |                      | 1717 UNI\  | ERSITY DR      | IVE SOUTHEAST   |           |                  |
| TALAHI            | NURSING AND REHA     | B CENTER   | OUD, MN 50     |   |           |                  |
|                   | OLIMAN DV OTA        |  | 1              |   | NA I      |                  |
| (X4) ID<br>PREFIX |                      | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL | ID<br>PREFIX   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL |           | (X5)<br>COMPLETE |
| TAG               |                      | SC IDENTIFYING INFORMATION)                      | TAG            | CROSS-REFERENCED TO THE APPROPRIES                          |           | DATE             |
|                   |                      |  |                | DEFICIENCY)   |           |                  |
| 2 020             | Continued From no    | go 14  | 2 830          |   |           |                  |
| 2 830             | Continued From pa    | ge 14  | 2 030          |   |           |                  |
|                   | weeks prior to his a | rrest and subsequent                             |                |   |           |                  |
|                   |                      | nursing home. G-A then                           |                |   |           |                  |
|                   |                      | which led up to 11/6/20 and                      |                |   |           |                  |
|                   |                      | Iting another resident. G-A                      |                |   |           |                  |
|                   |                      | been found masturbating in                       |                |   |           |                  |
|                   |                      | ), and then expressed the                        |                |   |           |                  |
|                   |                      | ed her regarding moving R2 to                    |                |   |           |                  |
|                   |                      | he had previously been                           |                |   |           |                  |
|                   | witnessed standing   | in the doorway of another                        |                |   |           |                  |
|                   |                      | d "making inappropriate sexual                   |                |   |           |                  |
|                   |                      | er, the facility never provided                  |                |   |           |                  |
|                   | the documentation    | to her of him doing that as it                   |                |   |           |                  |
|                   | had just been expre  | essed verbally to her by a staff                 |                |   |           |                  |
|                   | member whom she      | could not recall. G-A stated                     |                |   |           |                  |
|                   | she was not notified | timely of R2 refusing the                        |                |   |           |                  |
|                   | laboratory draw, no  | r the subsequent holding of                      |                |   |           |                  |
|                   |                      | edications, which was                            |                |   |           |                  |
|                   |                      | the nursing home should                          |                |   |           |                  |
|                   |                      | and he could have been                           |                |   |           |                  |
|                   |                      | ted sooner before sexually                       |                |   |           |                  |
|                   |                      | e. Further, G-A stated R2 was                    |                |   |           |                  |
|                   |                      | ail with multiple charges                        |                |   |           |                  |
|                   |                      | n from the sexual assault                        |                |   |           |                  |
|                   |                      | set as she believed the entire                   |                |   |           |                  |
|                   | •                    | ehaviors and subsequent                          |                |   |           |                  |
|                   |                      | nother resident could have                       |                |   |           |                  |
|                   |                      | ne facility had responded                        |                |   |           |                  |
|                   |                      | reiterated, "I believe this could                |                |   |           |                  |
|                   | have been prevente   |  |                |   |           |                  |
|                   | z z z z n pro ronk   |  |                |   |           |                  |
|                   | R2's quarterly MDS   | , dated 9/29/20, identified R2                   |                |   |           |                  |
|                   |                      | (a disorder which affects a                      |                |   |           |                  |
|                   |                      | nink, feel, and behave clearly)                  |                |   |           |                  |
|                   |                      | itive impairment. Further, R2                    |                |   |           |                  |
|                   |                      | allucinations, delusions or                      |                |   |           |                  |
|                   |                      | haviors, and required only                       |                |   |           |                  |
|                   |                      | nbulation in the corridor and                    |                |   |           |                  |
|                   | his room.            | modiation in the confluor and                    |                |   |           |                  |
|                   | ino room.            |  |                |   |           |                  |
|                   | R2's most recent P   | sychotropic Medication                           |                |   |           |                  |

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| winnesc                  | ota Department of He  | eaim  |                     |  |                   |                          |
|--------------------------|---|---|---------------------|--|-------------------|--------------------------|
|                          | NT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |                     | E CONSTRUCTION   | (X3) DATE<br>COMP | SURVEY<br>LETED          |
|                          |   |   |                     |  | _                 |                          |
|                          |   | 00614   | B. WING             |  | 11/1              | 8/2020                   |
| NAME OF I                | PROVIDER OR SUPPLIER  | STREET AD   | DRESS, CITY, S      | STATE, ZIP CODE  |                   |                          |
|                          |   | 1717 UNI  |                     | IVE SOUTHEAST  |                   |                          |
| TALAHI                   | NURSING AND REHA  | BCENTER   | OUD, MN 5           |  |                   |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE              | (X5)<br>COMPLETE<br>DATE |
| 2 830                    | Continued From pa   | ge 15   | 2 830               |  |                   |                          |
|                          | Review and Evalua R2 had schizophrer psychotropic medic antipsychotic), clon anxiety), and clozar target behavior whim was listed as happer assessment listed a which read, "Do the resident to present others of interfer care?" This was an assessment identification management as, "On R2's care plan, date communication def "Anticipate and medication and possible properties and medication and possible properties and medication help R2 meet this good to be a diverse side effect restlessness. Furth was considered a vice cognitive impairment interventions which behavioral issues with (IDT), evaluating for issues are identified close observation." | tion, dated 9/22/20, identified nia and consumed several rations including loxapine (an azepam (used to reduce oine. The form listed a primary ch read, "Hearing voices." This ratio power two weeks. The a radio-button style question are behaviors cause the a danger to themselves or e with the staff's ability to give swered, "No." Further, the led R2's behaviors and controlled."  The data of the care plan listed a ficit and directed staff to, et needs." R2 consumed cation and the care plan listed a for psychotropic medication as with several interventions to goal including, but not limited to emedication(s) as ordered, pharmacist and physician on ctions, and monitoring for some including agitation and the care plan identified R2 rulnerable adult due to his ents and outlined several included discussing with the interdisciplinary team or possible causative factors if did, and, "Resident requires are plan lacked further a would be closely observed to |                     |  |                   |                          |
|                          |   | d, including progress notes, identified the following:  |                     |  |                   |                          |

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|                          | ENT OF DEFICIENCIES NOF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SI COMPLE  |   |                     |   |                                |                          |
|--------------------------|--|---|---------------------|---|--------------------------------|--------------------------|
|                          |  | 00614   | B. WING             |   |                                | C<br><b>18/2020</b>      |
|                          | PROVIDER OR SUPPLIER   | B CENTER 1717 UI  | , ,                 | STATE, ZIP CODE<br>RIVE SOUTHEAST<br>6304   |                                |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| 2 830                    | On 8/18/20, a progrordered loxapine with (mg) due to an abnorders to follow-up practitioner (NP)-A  On 10/1/20, a progrefused his bath denot identify any other R2 despite refusing  On 10/15/20, a FOO recorded which lister for review. R2 was schizophrenia and I 8/18/20) was identificated impairment of the review in the restlessness. If further information of including how often happening, if at all, demonstrated episoridentified a section interventions," which impairments in the motion of the restless in t | ress note identified R2's as reduced to 25 milligrams ormal ECG. There were with the psychiatric nurse in one month.  ress note identified R2 had spite reproach. The note dider demonstrated behaviors by his bath.  CUS progress note was ed, "Behaviors," as the reason recorded as having R2's loxapine reduction (from fied. R2 had moderate and a section labeled, dentified R2 as having anxiety dowever, the note lacked any on these listed behaviors, the behaviors were or specifics around any odes of them. Further, the not labeled, "Care plan th directed, "Notify MD th any mood changes are informed approach observing ovide opportunities for | n<br>dee            |   |                                |                          |

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|                          | NT OF DEFICIENCIES OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA  | , ,                       | E CONSTRUCTION   | (X3) DATE<br>COMP | SURVEY<br>LETED          |
|--------------------------|--|--|---------------------------|--|-------------------|--------------------------|
| 712 . 271                | o. oo  |  | A. BUILDING:              |  |                   |                          |
|                          |  | 00614  | B. WING                   |  | 11/1              | )<br>8/2020              |
| NAME OF I                | PROVIDER OR SUPPLIER   | STREET AD  | DRESS, CITY, S            | STATE, ZIP CODE  |                   |                          |
| TALAHI                   | NURSING AND REHA   | AB CENTER  | VERSITY DR<br>.OUD, MN 50 | IVE SOUTHEAST<br>6304  |                   |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRI<br>DEFICIENCY) | JLD BE            | (X5)<br>COMPLETE<br>DATE |
| 2 830                    | 10/19/20, and it ware-approach R2 and so R2's clozapine properties of R2/20, identified practitioner (NP)-B to allow the laborate medication was avaresult. R2 was lister clozapine everyday responded, "Please keep trying with labordering provider I On 10/23/20, a later recorded which ide on R2's refusal to a clozapine. The notenystrom appointment possible]. Nystrom made for 11/12/20. On 10/31/20, a properties of the recorded anything began yelling at wriminutes a [NA] can looked at her and y [three times]." R2 we good portion" of the walking around, includor and pushing by the statempted by the state | efused the laboratory draw on s ordered they continue to d attempt to obtain the lab(s) prescription could be filled.  enevive Progress Note, dated R2's medical nurse was updated on R2's refusal ory draw on 10/19/20, so no allable for administration as a d as consuming 500 mg of a The note outlined NP-B call and tell [nursing home] to be seen the progress note was entified NP-B had been updated allow laboratory draw(s) for his econtinued, "NP[-B] wanted ent made ASAP [as soon as [psychiatry clinic] appointment."  gress note identified R2 came as the best of the staff, but then "  gress note identified R2 came as the down the hallway and he relled 'you fucking nigger' X3 was recorded as spending "a eday outside of his room cluding standing by the front outtons in attempt to open it. By evidence of interventions araff to calm or redirect R2 | 2 830                     |  |                   |                          |
|                          |  | " very agitated, restless and  |                           |  |                   |                          |

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| STATEMEN                 | NT OF DEFICIENCIES OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | , ,                 | E CONSTRUCTION   | (X3) DATE<br>COMP | SURVEY<br>LETED          |
|--------------------------|--|--|---------------------|--|-------------------|--------------------------|
|                          |  | 00614  | B. WING             |  | 11/1              | 8/2020                   |
| NAME OF I                | PROVIDER OR SUPPLIER   |  | 1                   | STATE, ZIP CODE  | 1                 | 0/2020                   |
|                          | NURSING AND REHA   | B CENTER 1717 UNIV   | VERSITY DR          | IVE SOUTHEAST  |                   |                          |
|                          | 010000000000000000000000000000000000000  |  | OUD, MN 50          |  | 1011              |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE             | (X5)<br>COMPLETE<br>DATE |
| 2 830                    | Continued From pa  | nge 18   | 2 830               |  |                   |                          |
| 2 000                    | having hallucination at him and resident you' drew his arm going to punch nursis very abnormal be nurse sat down new which was effective note identified the I draw R2's lab(s) on what caused reside provided education draw, however, the be observed as resaggression or agita approached nurses. Nurse asked what ir resident replied 'Th hates me, and that identified the nurse proceeded to hug that and start crying. Gowas contacted due restlessness and a twice a day as-need (3) day period " to | ns during shift [nurse] waved at flicked nurse off, said 'fuck on back as if acting he was see." The note continued, "This ehavior for resident." The act to R2 and talked with him in calming him down. The aboratory had attempted to a the prior shift which " is ent to become upset." R2 was on the importance of the lab note outlined R2 continued to atless but without physical action. The note continued, "[R2] stating 'I am hearing voices.' the voices were telling him and that no one likes me, everyone I should just die." The note a provided comfort to R2 whom the nurse and become upset enevive (physician service) to R2's continued on order for clonazepam 0.5 mg ded was provided for a three until cozapine issue was administered to R2 and the |                     |  |                   |                          |
|                          | note, dated 10/31/2 had contacted the sexperiencing increase hallucinations pa [sic], though a scrip are waiting for lab very patient continues to concerned for his a   | g Genevive Phone Encounter 20, identified the nursing home service reporting R2 " is ased agitation, aggression and atient was receiving Clozapine of has not been sent as they work to be completed, though or refuse labs staff are agitation." The note identified  |                     |  |                   |                          |
|                          | experiencing increated hallucinations pate [sic], though a script are waiting for laby patient continues to concerned for his at an order for clonaze  | ased agitation, aggression and attent was receiving Clozapine of has not been sent as they work to be completed, though o refuse labs staff are  |                     |  |                   |                          |

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|                          | NT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE<br>A. BUILDING: | E CONSTRUCTION   |                                | E SURVEY<br>PLETED       |
|--------------------------|--|---|-------------------------------|--|--------------------------------|--------------------------|
|                          |  | 00614   | B. WING                       |  | <b> </b>                       | C<br><b>18/2020</b>      |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET A  | DDRESS, CITY, S               | TATE, ZIP CODE   |                                |                          |
| TALAHI                   | NURSING AND REHA   | BCENTER   | IVERSITY DRI<br>LOUD, MN 56   | VE SOUTHEAST<br>304  |                                |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>'MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG           | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY | ON SHOULD BE<br>IE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| 2 830                    | with, "Nursing staff PCP [primary care his agitation."  On 11/1/20, anothe which identified R2 around facility throushift] report, resider did not sleep. Reside cigarettes for him. Want! I'm over 18!' reassurance provid staff member at frostaff member when threw desk supplies outlined education a provided, however, more angry as staff provided time and sand " appeared to refuse medications  On 11/2/20, a progrentered R2's room and was laying in b R2 proceeded to coprovided R2 his orahis right hand arour then took his hand The note identified appropriate to grab left the room.  On 11/2/20, a subsidentified, "New believed in the said of the sai | are to follow-up with patient's provider] this week regarding r progress note was recorded was " noted to be pacing up out the morning. Per [night at was up all night pacing and dent asking staff to purchase Yelling at staff 'I can smoke if I Emotional support and ed. Resident then approached to desk. Became upset with unable to get cigarettes and a caross lobby." The note and encouragement was R2 " Becomes more and fre-approach." R2 was then space to express his feelings o calm down but continues to |                               | DEFICIENCY   |                                |                          |
|                          | were received from   | ress note identified order(s)<br>NP-B to send R2 to the<br>ER). A subsequent note, dated  |                               |  |                                |                          |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |                          | E CONSTRUCTION  | (X3) DATE<br>COMP | SURVEY<br>LETED          |
|---|---|--------------------------|---|-------------------|--------------------------|
|   |   |                          |   |                   |                          |
|   | 00614   | B. WING                  |   | 11/1              | 8/2020                   |
| NAME OF PROVIDER OR SUPPLIER  |   |                          | STATE, ZIP CODE   |                   |                          |
| TALAHI NURSING AND REHA   | B CENTER  | /ERSITY DR<br>OUD, MN 56 | IVE SOUTHEAST<br>6304   |                   |                          |
| PREFIX (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | D BE              | (X5)<br>COMPLETE<br>DATE |
| (G)-A and the nurse laboratory draw corpresent. The note represent. The note represent. The note represent in the picked up an orange his guardian." NP-E continued inability to R2 " had been of weeks, and that write to be sent in to the R2 was sent to the R2 was sent to the R2 was sent to the R2 had gone without two weeks as he will draws. The note ide [due to] not getting present, and typical labs drawn, so the seeking an order for addendum was dicted. "I [NP-B] don't man orders this Upon nurses stated that one eded, now need threw a traffic cone states that she has and aggressive as ED. Facility staff also behaviors at this tin provided to send R2."  R2's corresponding 11/3/20, identified Fachief complaint listed R2 reported he was he resided at the note. | R2 had met with his guardian e attempted to get the needed impleted while she was ecorded, " resident yelled taking any labs', then resident e traffic cone and threw it at 8 was updated regarding the o draw the needed lab(s) and if his clozapine for almost two iter believed resident needed hospital for further evaluation." hospital ER via ambulance.  I Genevive Progress Note, tified NP-B was contacted as ut his ordered clozapine for as refusing to allow laboratory entified, "Behaviors increased med." R2's guardian was able to get R2 to have nursing home staff were or the needed lab draw(s). An tated by NP-B which identified, age this, his psych provider calling site nurse back, site orders for labs no longer okay to send to ED [R2] at his guardian. Guardian never seen [R2] as agitated the is right now, wants sent into so aren't able to manage ne." A telephone order was | 2 830                    |   |                   |                          |

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Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIPLI<br>A. BUILDING:  | E CONSTRUCTION |  | (X3) DATE SURVEY<br>COMPLETED |                          |  |
|--|--|--|----------------|--|-------------------------------|--------------------------|--|
|  |  | 00614  | B. WING        | B. WING  |                               | C<br>11/18/2020          |  |
|  | PROVIDER OR SUPPLIER  NURSING AND REHA   | B CENTER 1717 UNI  | , ,            | TATE, ZIP CODE  VE SOUTHEAST  3304   |                               |                          |  |
| (X4) ID<br>PREFIX<br>TAG   | REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL  |  |                | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | ON SHOULD BE<br>E APPROPRIATE | (X5)<br>COMPLETE<br>DATE |  |
| 2 830  | nurses. R2 voiced is been sent to the EE suicidal ideation. R2 were completed and back to the nursing he is now willing medications." Furth progress note, date reported not taking him feel "stressed or return to the nursing behavior and I'll tak command hallucina but acknowledged I times. Further, R2's which identified high behavior(s) towards return to the nursing the suited to the nursing the suited to the suited | ne was unaware why he had b, but did endorse having 2's needed laboratory draw(s) d a behavioral consultation I cleared him for discharge home. R2 was recorded as, "to go back on his er, R2's Behavioral Access ed 11/3/20, identified R2 his medications as they made but." R2 voiced he would g home and " be on my best e my medicine." R2 denied ations to hurt himself or others, naving visual hallucinations at a clinical status was listed hly impulsive and aggressive s others. R2 was cleared to g home. |                |  |                               |                          |  |
|  | On 11/4/20, a progress note identified R2 returned from the ER and had several labs, including a urinalysis completed. The results were negative for a bladder infection and no new medication or treatment orders were provided. The note concluded, "He is to see [nurse practitioner] in 2 days."   |  |                |  |                               |                          |  |
|  | identified the pharm completed laborato his Clozapine [sic] I possible." The phar contact the hospital results and would conte concluded, "Wigharmacy." Further 11/4/20, identified to contacted. The pharmacy.  | equent progress note nacy had been updated on the ry draws, and R2 " needed medication as soon as macist voiced they would to review the laboratory ontact the nursing home. The riter is awaiting call back from an additional note, dated he pharmacy was again rmacist voiced they needed in how many days R2 had   |                |  |                               |                          |  |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:   |  |                          | (X3) DATE SURVEY<br>COMPLETED   |  |            |  |
|--|--|--|--|--------------------------|---|--|------------|--|
|  |  |  |  |                          |   |  | С          |  |
|  |  | 00614  |  | B. WING                  | 3. WING   |  | 11/18/2020 |  |
| NAME OF PROVIDER OR SU   | PPLIER   |  |  |                          | STATE, ZIP CODE   |  |            |  |
| TALAHI NURSING ANI   | REH  | AB CENTER  |  | /ERSITY DR<br>OUD, MN 50 | IVE SOUTHEAST<br>6304   |  |            |  |
| PREFIX (EACH DE  | (EACH DEFICIENCY MUST BE PRECEDED BY FULL  |  |  | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLE DATE |  |            |  |
| home expre last adminis expressed the who prescribe to be re-titral been off the message had note conclude pharmacist.  On 11/6/20, identified R2 approximate he was goin When he asked CNA machine but from east [s rooms and of ound him rate for help. The walked him of nursing] apolice were [1:30 a.m.]. adult] report R2's Medical dated 10/20, physician or subsequent was listed for everyday; where medical consumed be 11/5/20, the doses of the numerous e | this classed haration ney need the ted given medical beet led, "V at 1:30 to go didn't so go so CNA c] and there a ping a pack to a called for more tion A 20 to 1 dered admin r clozal medical medica | lozapine; which ad been "two" The pharmeded to speake medication to the medication. The pharmeder is awaiting as a.m. a progressen coming to 30 p.m. (on 11 set a soda. The come back in se if he was stouldn't find he come back in se if he was stouldn't find he come back in se if he was stouldn't find he come back in se if he was stouldn't find he come back in se if he was stouldn't find he come back in se if he was stouldn't find he come and the police on the police of t | weeks since his macist then with the provider of see if it needed of time R2 had armacist voiced a rovider, and the ing a respond from the sees note put of his room at 1/5/20) and voiced a note continued, "15 minutes will by popular. Writer, nurse a up to check all wilding [NA-A] and screamed and him off her and the DON [director called. The at the took him about a took him a to | 2 830                    |   |  |            |  |

Minnesota Department of Health

STATE FORM 8TR511 If continuation sheet 23 of 53

Minnesota Department of Health

| AND DI AN OF CORRECTION \ \ \ \ \ IDENTIFICATION NUMBER:  | ULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED |
|---|---|
|   | c   |
| 00614 B. WIN  | 11/10/2020                                      |
|   | CITY, STATE, ZIP CODE  TY DRIVE SOUTHEAST       |
| TALAHI NURSING AND REHAB CENTER SAINT CLOUD,  |   |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES II PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TA   | FIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE  |
| 2 830 Continued From page 23 2 83   | 0   |
| pharmacy."  |   |
| R2's Documentation Survey Report, dated 9/2020 to 11/2020, was reviewed and identified R2's recorded behaviors using a legend and corresponding code system. The report demonstrated R2 had no recorded behaviors, including hitting, threatening, cursing at others or sexually inappropriate behaviors, in the month of September and October 2020. However, R2 had a single episode of sexually inappropriate behavior recorded on 11/2/20 which was outlined as, "disrupted [the] environment." R2 was re-directed but the intervention was ineffective. No other behaviors were recorded for R2 on these reports despite the repeated progress note(s) which identified him as cursing, throwing objects and wandering around the facility.  R2's medical record was reviewed and lacked evidence R2's escalating behaviors had been comprehensively assessed to help determine all contributing factors and subsequent interventions to help reduce and/or eliminate them despite the abrupt stopping of his prescribed antipsychotic medication. There was no evidence the facility had implemented any subsequent increased monitoring or supervision of R1 despite his antipsychotic medication being abruptly stopped and the ongoing documentation of escalating behaviors, including physically throwing items and being found masturbating in his room which had not been recorded or identified before 11/2/20 in his record.  When interviewed on 11/13/20, at 9:41 a.m. NA-A was interviewed and explained R2 was more independent with his needs and typically did not |   |

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| STATEMEN                 | NT OF DEFICIENCIES OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |                     | E CONSTRUCTION   | (X3) DATE       | SURVEY<br>LETED          |
|--------------------------|--|---|---------------------|--|-----------------|--------------------------|
|                          |  |   | A. BUILDING:        |  |                 |                          |
|                          |  | 00614   | B. WING             |  | C<br>11/18/2020 |                          |
| NAME OF I                | PROVIDER OR SUPPLIER   | STREET AD   | DRESS, CITY, S      | STATE, ZIP CODE  |                 |                          |
|                          |  | 1717 UNIV   | ERSITY DR           | IVE SOUTHEAST  |                 |                          |
| IALAHI                   | NURSING AND REHA   | B CENTER SAINT CL   | OUD, MN 50          | 6304   |                 |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUI<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE           | (X5)<br>COMPLETE<br>DATE |
| 2 830                    | Continued From pa  | ge 24   | 2 830               |  |                 |                          |
|                          | being sexually assaleft his room on the was going to walk of was gone for "about working (RN-B) had for R2 as he had "b days" and had not you she opened a female saw R2 on top of he underwear on as he "having sex with he naked buttocks were her peri-area "movishe immediately ye but R2 just turned a continued assaultin voiced she yelled for members then respite female resident room. NA-A explain and R2 was subsequiring home. Furtinever known R2 to prior, but verified here  | aulted and explained R2 had night of 11/5/20, voicing he down to the soda machine. R2 t 15 minutes" when the nurse d asked staff to start looking leen acting weird the last few yet returned yet. NA-A stated le resident's closed door and er in her bed with no pants or e held her down and was r." NA-A expressed R2's re visible immediately above ng up and down." NA-A stated lled at R2 to "get off of her," and looked at NA-A while he g the female resident. NA-A or help and male staff bonded and removed R2 from s bed and took him back to his ned the police were contacted quently removed from the her, NA-A explained she had demonstrate sexual behaviors e was not on any formal itoring despite being identified |                     |  |                 |                          |
|                          | described R2 as so care" and would oft home at night addir other resident' room verified R2 was fou  | 11/13/20, at 10:20 a.m. RN-B meone who "didn't need much en walk around the nursing ng R2 was not known to enterns to her knowledge. RN-B nd in a female resident's roomd sexually assaulted her which  |                     |  |                 |                          |
|                          | resulted in the police responded and inte RN-B, then "admitted then removed from recalled R2 never to the resulted R4 nev | re being contacted. The police rviewed R2 who, according to ed he had done it" and was the nursing home. RN-B ypically demonstrated any gressive behaviors which she  |                     |  |                 |                          |

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Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X2) MULTIPL<br>A. BUILDING:   | E CONSTRUCTION   |   | (X3) DATE SURVEY<br>COMPLETED |  |                          |  |
|---|---|--|--|---|-------------------------------|--|--------------------------|--|
|   |   |  |  |   |                               |  | С                        |  |
|   |   | 00614  |  | B. WING   |                               |  | 18/2020                  |  |
| NAME OF   | PROVIDER OR SUPPLIER  |  | STREET AD  | DRESS, CITY, S  | STATE, ZIP CODE               |  |                          |  |
| TALALI  | NUDCING AND DELIA   | D CENTED   | 1717 UNI   | VERSITY DR  | IVE SOUTHEAST                 |  |                          |  |
| TALAHI NURSING AND REHAB CENTER SAINT CI  |   |  |  | OUD, MN 50  | 3304                          |  |                          |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY MUST BE PRECEDED BY FULL   |  |  | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) |                               |  | (X5)<br>COMPLETE<br>DATE |  |
| 2 830   | 0 Continued From page 25  |  |  | 2 830   |                               |  |                          |  |
|   | could recall, howev become "more rest the 11/5/20 incident and discharge from stated she was "not more restless and there had been received aggressive of incident on 11/5/20 notes since he was the nursing home.  On 11/13/20, at 1:0 manager (RN)-A ar   | less" in the wee t and R2's substant R2's substant R2's substant R2 hexpressed she "orded notes out masturbating processed and rested and rested for the R2 however, had be arrested and rested for P.m. registerested.  | ks leading up equent arrest me. RN-B nad become wasn't aware" lining him as prior to the learned of the emoved from  |   |                               |  |                          |  |
|   | (LSW)-A were inter nursing home after to discharge to a verification to the weeks leading 11/5/20. LSW-A expressive a resident quarterly basis using with a daily review of stand-up meeting. The progress note (date displayed no halluch behaviors at that tirconcerns with him were actually unsure him as having resting. LSW-A stand-up meeting. LSW-A stand-up how to use the admitted using clozens. | viewed. R2 adnormal a hospitalization a hospitalization and read him to have to gup to the incice plained the facility and their behalf of they reviewed from they reviewed from they reviewed from they recalled at the meeting at the meeting at the meeting at they were still "m. RN-A explain." | nitted to the n and planned e when able to. esponsive" and behaviors prior dent on ity typically viors on a stings" along 19th the R2's FOCUS diverified R2 essive ed "no major adding they ided to record xiety at that 19th gs were a trying to figure 19th 19th 19th 19th 19th 19th 19th 19th |   |                               |  |                          |  |
|   | and consistently too<br>10/19/20, when he<br>monitoring and the<br>prescription. RN-A<br>contacted R2's nurs  | ok the medication refused the route pharmacist would be capitation.  | on until<br>tine laboratory<br>ald not fill the<br>art nurse then  |   |                               |  |                          |  |

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Minnesota Department of Health

| WIIIIII           | na Department of Tie   | i i   |                                |   |           |                  |  |  |
|-------------------|------------------------|---|--------------------------------|---|-----------|------------------|--|--|
|                   | NT OF DEFICIENCIES     | (X1) PROVIDER/SUPPLIER/CLIA                                   | (X2) MULTIPL                   | E CONSTRUCTION  | (X3) DATE |                  |  |  |
| AND PLAN          | OF CORRECTION          | IDENTIFICATION NUMBER:  | A. BUILDING:                   |   | COMP      | LETED            |  |  |
|                   |                        |   |                                |   |           | 2                |  |  |
|                   |                        | 00614   | B. WING                        |   |           | 8/2020           |  |  |
| NAME OF I         | PROVIDER OR SUPPLIER   | STREET AD   | ADDRESS, CITY, STATE, ZIP CODE |   |           |                  |  |  |
|                   |                        |   |                                | IVE SOUTHEAST   |           |                  |  |  |
| TALAHI            | NURSING AND REHA       | AB CENTER   | OUD, MN 5                      |   |           |                  |  |  |
|                   | OLIMA AA DV OTA        |   | 1                              |   |           | 0.5              |  |  |
| (X4) ID<br>PREFIX |                        | ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL           | ID<br>PREFIX                   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL |           | (X5)<br>COMPLETE |  |  |
| TAG               |                        | SC IDENTIFYING INFORMATION)                                   | TAG                            | CROSS-REFERENCED TO THE APPROI                              |           | DATE             |  |  |
|                   |                        |   |                                | DEFICIENCY)   |           |                  |  |  |
| 2 830             | Continued From pa      | nge 26  | 2 830                          |   |           |                  |  |  |
|                   | '                      |   |                                |   |           |                  |  |  |
|                   |                        | 2/20) who voiced she did not                                  |                                |   |           |                  |  |  |
|                   |                        | arting new medication or                                      |                                |   |           |                  |  |  |
|                   |                        | pine and directed an  |                                |   |           |                  |  |  |
|                   |                        | 2's psychiatry team should be                                 |                                |   |           |                  |  |  |
|                   |                        | is possible. RN-A stated she contact the psychiatric team via |                                |   |           |                  |  |  |
|                   |                        | r, was unable to reach anyone                                 |                                |   |           |                  |  |  |
|                   |                        | age. A return call was never                                  |                                |   |           |                  |  |  |
|                   |                        | d RN-A verified she never                                     |                                |   |           |                  |  |  |
|                   |                        | contact the psychiatry provider                               |                                |   |           |                  |  |  |
|                   |                        | "didn't feel anybody was in                                   |                                |   |           |                  |  |  |
|                   |                        | They verified no increased                                    |                                |   |           |                  |  |  |
|                   |                        | itoring had been placed on R2                                 |                                |   |           |                  |  |  |
|                   |                        | opping his antipsychotic                                      |                                |   |           |                  |  |  |
|                   |                        | er, RN-A added such an  |                                |   |           |                  |  |  |
|                   |                        | be a good intervention to do                                  |                                |   |           |                  |  |  |
|                   |                        | bruptly ceased their  |                                |   |           |                  |  |  |
|                   |                        | and LSW-A then reviewed R2's                                  |                                |   |           |                  |  |  |
|                   | medical record and     | progress notes. They  |                                |   |           |                  |  |  |
|                   | explained the beha     | viors being recorded after                                    |                                |   |           |                  |  |  |
|                   | 10/19/20 were not i    | normal behaviors R2 had                                       |                                |   |           |                  |  |  |
|                   | demonstrated prior     | , and expressed no  |                                |   |           |                  |  |  |
|                   | assessment or disc     | cussion of them had occurred                                  |                                |   |           |                  |  |  |
|                   |                        | p meeting(s). RN-A voiced the                                 |                                |   |           |                  |  |  |
|                   |                        | enting the behaviors should                                   |                                |   |           |                  |  |  |
|                   |                        | management team was   |                                |   |           |                  |  |  |
|                   |                        | added they had "definitely not"                               |                                |   |           |                  |  |  |
|                   |                        | nese behaviors including the                                  |                                |   |           |                  |  |  |
|                   |                        | sical aggression and  |                                |   |           |                  |  |  |
|                   |                        | recalled the incident involving                               |                                |   |           |                  |  |  |
|                   |                        | ting a female resident and                                    |                                |   |           |                  |  |  |
|                   |                        | not ever considered and                                       |                                |   |           |                  |  |  |
|                   |                        | splayed behaviors R2 had                                      |                                |   |           |                  |  |  |
|                   |                        | luding masturbation, when he                                  |                                |   |           |                  |  |  |
|                   |                        | king his antipsychotic  |                                |   |           |                  |  |  |
|                   |                        | eiterated if they had been                                    |                                |   |           |                  |  |  |
|                   |                        | naviors and known they were                                   |                                |   |           |                  |  |  |
|                   |                        | ould have done some "more sessment" of them and taken         |                                |   |           |                  |  |  |
|                   |                        | e more seriously." LSW-A                                      |                                |   |           |                  |  |  |
|                   | une situation a little | , more senously. LOW-A  |                                |   |           |                  |  |  |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIPL<br>A. BUILDING:   | E CONSTRUCTION      |   | (X3) DATE SURVEY<br>COMPLETED |                          |  |
|--|--|--|---------------------|---|-------------------------------|--------------------------|--|
|  |  |  | D MINO              |   |                               | С                        |  |
|  |  | 00614  | B. WING             |   | 11/                           | 18/2020                  |  |
| NAME OF  | PROVIDER OR SUPPLIER   |  | , ,                 | STATE, ZIP CODE   |                               |                          |  |
| TALAHI   | NURSING AND REHA   | B CENTER   | CLOUD, MN 5         | IVE SOUTHEAST<br>6304   |                               |                          |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTIO<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | N SHOULD BE<br>E APPROPRIATE  | (X5)<br>COMPLETE<br>DATE |  |
| 2 830  | added she "didn't ke escalating like that" contacted the facilit tried to include them these crazy behavion ochanges were mfrom a room changincident involving R "maybe some educ RN-A stated the bethe management teto address" in upco On 11/13/20, at 3:1 practitioner (NP)-B someone who was prior to 10/19/20, at aware of any behave being abruptly stop not personally orde the prescriber is recertification as it was medication." The malaboratory values to at times, pharmacie medication until the result of those thing psychiatry team was clozapine. NP-B exalaboratory monitoring provider service was days later on 10/22 medication orders was the nursing home have resulted what they ord NP-B stated they was contacted. | now the behaviors were and voiced she would have by psychiatry team (ACP) and make the sylvalustry team (ACP) and the sylvalustry team (ACP) and added to R2's care plan, aside the sylvalustry the sylvalustry team the sylvalustry team the sylvalustry team was needed. Further, thaviors not being forwarded the sylvalustry team was something "we need sylvalustry the sylvalustry team was something to the clozapine was interviewed. R2 was "very reserved" and "quiet" and NP-B verified she was "not viors" prior to the clozapine ped. NP-B explained she did are or manage R2's clozapine and sylvalustry to the checked periodically and the sylvalustry team of the sylvalustry team of the sylvalustry team and she would not even release the sylvalustry the sylvalustry team and she would have the sylvalustry team of | d<br>o              |   |                               |                          |  |
|  |  | y dose of clonazepam (a<br>r anxiety) was provided. Then   |                     |   |                               |                          |  |

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Minnesota Department of Health

| STATEMEN                 | NT OF DEFICIENCIES OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | , ,                 | E CONSTRUCTION  | (X3) DATE<br>COMP | SURVEY<br>LETED          |
|--------------------------|--|--|---------------------|---|-------------------|--------------------------|
|                          |  |  |                     |   |                   | ;                        |
|                          |  | 00614  | B. WING             |   | 11/1              | 8/2020                   |
| NAME OF I                | PROVIDER OR SUPPLIER   | STREET ADI   | DRESS, CITY, S      | STATE, ZIP CODE   |                   |                          |
| TALAHI                   | NURSING AND REHA   | AB CENTER  |                     | IVE SOUTHEAST   |                   |                          |
|                          | OLIMANA DV. OTA  |  | OUD, MN 50          |   | 201               | 0.5                      |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE              | (X5)<br>COMPLETE<br>DATE |
| 2 830                    | on 11/3/20, NP-B was now being very "two weeks" without NP-B stated this was had not had his cloordered him to be on ursing home felt thanymore. The ED of laboratory draw(s) and ursing home was clozapine restarted facility on 11/4/20. I aware R2's psychiat notified of his refus draw(s) and subsect voicing that was "un voiced if she had be service had not be on clonazepam soon helped to calm and he required treatmed sexually assaulted.  On 11/13/20, at 3:3 pharmacist (CP) was clozapine was a medication without doing so could yield schizophrenia sympleffects. Further, CF the specifics regard clozapine medication. | vas updated again and told R2 y aggressive and had gone for it his antipsychotic medication. as the first time she realized he zapine "for awhile" and then evaluated in the ED as the hey couldn't control him completed the necessary and, to her knowledge, the working on getting his when he returned to the NP-B expressed she was not atry team had never been al to allow the laboratory quent holding of his clozapine infortunate." Further, NP-B een told R2's psychiatry en updated and R2 had started oner, it may "potentially" have reduce R2's behaviors before ent in the ED and subsequently another resident.  37 p.m. the consulting as interviewed and explained edication typically used when is had not worked due to it's us "side effects" and required monitoring to ensure safety on it. CP voiced it "probably idea" to abruptly stop the slowly titrating down prior, and it the sudden return of proms or other adverse in stated she was unaware of ding R2 and his missed on; however, explained if he | 2 830               |   |                   |                          |
|                          | had stopped taking then had a return o   | the medication abruptly and f symptoms that perhaps a tic to help reduce or calm the   |                     |   |                   |                          |

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Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | , ,             | E CONSTRUCTION      |                     | (X3) DATE SURVEY<br>COMPLETED |  |         |  |
|---|---|-----------------|---------------------|---------------------|-------------------------------|--|---------|--|
| AND PLAN  | OF CORRECTION   | IDENTIFICA      | ATION NUMBER:       | A. BUILDING:        |                               | COM  | PLETED  |  |
|   |   |                 |                     |                     |                               |  | С       |  |
|   |   | 00614           |                     | B. WING             |                               | 11/  | 18/2020 |  |
| NAME OF   | PROVIDER OR SUPPLIER  |                 | STREET AD           | DRESS, CITY, S      | STATE, ZIP CODE               |  |         |  |
| TALALI  | NURSING AND REHA  | D CENTED        | 1717 UNI\           | /ERSITY DR          | IVE SOUTHEAST                 |  |         |  |
| IALANI  | NURSING AND REDA  | AB CENTER       | SAINT CL            | OUD, MN 50          | 6304                          |  |         |  |
| (X4) ID<br>PREFIX<br>TAG  | FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL   |                 | EDED BY FULL        | ID<br>PREFIX<br>TAG | (EACH CORRECTIVE ACTION SE    | PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOULD BE COMPOSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (COMPOSS OF THE APPROPRIATE DEFICIENCY) |         |  |
| 2 830   | Continued From page 20  |                 |                     | 2 830               | ,                             |  |         |  |
| 2 830   | Continued From page 29  |                 |                     | 2 630               |                               |  |         |  |
|   | symptoms may hav  |                 |                     |                     |                               |  |         |  |
|   | nursing home shou   |                 |                     |                     |                               |  |         |  |
|   | when the patient refuses medications and how to   |                 |                     |                     |                               |  |         |  |
|   | address it.   |                 |                     |                     |                               |  |         |  |
|   | On 11/17/20, at 11  | ·32 am the d    | lirector of nursing |                     |                               |  |         |  |
|   | (DON) was intervie  |                 |                     |                     |                               |  |         |  |
|   | received a telephor   |                 |                     |                     |                               |  |         |  |
|   | 11/6/20, and the staff voiced "something terrible has happened" which they described as finding R2 "raping our poor [female resident]." The DON |                 |                     |                     |                               |  |         |  |
|   |   |                 |                     |                     |                               |  |         |  |
|   |   |                 |                     |                     |                               |  |         |  |
|   | instructed them to  |                 |                     |                     |                               |  |         |  |
|   | and then contacted on the allegation. T   |                 |                     |                     |                               |  |         |  |
|   | arrived at the nursi  |                 |                     |                     |                               |  |         |  |
|   | present and voiced  |                 |                     |                     |                               |  |         |  |
|   | for "sexual miscone   |                 |                     |                     |                               |  |         |  |
|   | police he committe  |                 |                     |                     |                               |  |         |  |
|   | removed from the  |                 |                     |                     |                               |  |         |  |
|   | verified no formal s  |                 |                     |                     |                               |  |         |  |
|   | were placed on R2   |                 |                     |                     |                               |  |         |  |
|   | his antipsychotic m documented escala   |                 |                     |                     |                               |  |         |  |
|   | progress notes. Th  |                 |                     |                     |                               |  |         |  |
|   | itself, may or may r  |                 |                     |                     |                               |  |         |  |
|   | as he could have b  |                 |                     |                     |                               |  |         |  |
|   | many times before   |                 |                     |                     |                               |  |         |  |
|   | had no knowledge  |                 |                     |                     |                               |  |         |  |
|   | staff throughout his  |                 |                     |                     |                               |  |         |  |
|   | DON expressed R2  | •               | •                   |                     |                               |  |         |  |
|   | behaviors to their k<br>to find lesser care   |                 |                     |                     |                               |  |         |  |
|   | not required skilled  |                 |                     |                     |                               |  |         |  |
|   | becoming upset wi   |                 |                     |                     |                               |  |         |  |
|   | over various things   |                 |                     |                     |                               |  |         |  |
|   | made the decision   |                 |                     |                     |                               |  |         |  |
|   | just prior to the ass   | ault as R2 wa   | as "unpredictable"  |                     |                               |  |         |  |
|   | at times and would  |                 |                     |                     |                               |  |         |  |
|   | when he was irritat   |                 |                     |                     |                               |  |         |  |
|   | had heard about R   | 2 not getting h | nis scheduled       |                     |                               |  |         |  |

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| WIIIIII           | na Department of Tie | aiui  |                               |  |           |                  |  |
|-------------------|----------------------|---|-------------------------------|--|-----------|------------------|--|
|                   | NT OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA                                   | (X2) MULTIPL                  | E CONSTRUCTION   | (X3) DATE |                  |  |
| AND PLAN          | OF CORRECTION        | IDENTIFICATION NUMBER:  | A. BUILDING:                  |  | COMP      | LETED            |  |
|                   |                      |   |                               |  | l c       | )                |  |
|                   |                      | 00614   | B. WING                       |  | 11/1      | 8/2020           |  |
| NAME OF I         | PROVIDER OR SUPPLIER | STREET AN   | DDRESS, CITY, STATE, ZIP CODE |  |           |                  |  |
| TW WILL OT        | NOVIDEN ON OUT LIEN  |   |                               | IVE SOUTHEAST  |           |                  |  |
| TALAHI            | NURSING AND REHA     | B CENTER  | OUD, MN 50                    |  |           |                  |  |
|                   |                      |   |                               |  |           |                  |  |
| (X4) ID<br>PREFIX |                      | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL              | ID<br>PREFIX                  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE |           | (X5)<br>COMPLETE |  |
| TAG               |                      | SC IDENTIFYING INFORMATION)                                   | TAG                           | CROSS-REFERENCED TO THE APPROI                                     |           | DATE             |  |
|                   |                      |   |                               | DEFICIENCY)  |           |                  |  |
| 2 830             | Continued From pa    | nge 30  | 2 830                         |  |           |                  |  |
| 2 000             | •                    |   | 2 000                         |  |           |                  |  |
|                   |                      | nding out by the nurses station                               |                               |  |           |                  |  |
|                   |                      | ed they did not have the                                      |                               |  |           |                  |  |
|                   |                      | She could not recall the exact                                |                               |  |           |                  |  |
|                   |                      | old R2 had not been getting                                   |                               |  |           |                  |  |
|                   |                      | apine, but felt "pretty confident"                            |                               |  |           |                  |  |
|                   |                      | itil the week just prior to the<br>e female resident. The DON |                               |  |           |                  |  |
|                   |                      | tion would have been to be                                    |                               |  |           |                  |  |
|                   |                      | day he initially refused the                                  |                               |  |           |                  |  |
|                   |                      | d subsequently had his  |                               |  |           |                  |  |
|                   |                      | vided. The DON stated she                                     |                               |  |           |                  |  |
|                   |                      | o ensure the guardian and                                     |                               |  |           |                  |  |
|                   |                      | d on the situation, and they                                  |                               |  |           |                  |  |
|                   |                      | imes to draw the needed                                       |                               |  |           |                  |  |
|                   |                      | t R2 would not allow it. The                                  |                               |  |           |                  |  |
|                   |                      | R2's progress note(s) in his                                  |                               |  |           |                  |  |
|                   |                      | fied there were "more   |                               |  |           |                  |  |
|                   | behaviors documer    | nted" after 10/19/20, and                                     |                               |  |           |                  |  |
|                   | added her expectat   | ion was for RN-A and LSW-A                                    |                               |  |           |                  |  |
|                   | to review the progre | ess notes "each day" and bring                                |                               |  |           |                  |  |
|                   |                      | lating behaviors and missed                                   |                               |  |           |                  |  |
|                   |                      | IDT meeting so they can be                                    |                               |  |           |                  |  |
|                   |                      | essed including reviewing for                                 |                               |  |           |                  |  |
|                   |                      | atterns and other issues. The                                 |                               |  |           |                  |  |
|                   |                      | missed doses of clozapine                                     |                               |  |           |                  |  |
|                   |                      | at their IDT meetings and                                     |                               |  |           |                  |  |
|                   |                      | ssues been presented at the                                   |                               |  |           |                  |  |
|                   |                      | d have intervened" and made                                   |                               |  |           |                  |  |
|                   |                      | ction was taken adding RN-A                                   |                               |  |           |                  |  |
|                   |                      | esponsible to ensure the                                      |                               |  |           |                  |  |
|                   |                      | sessed and "put all that<br>I stated those assessments        |                               |  |           |                  |  |
|                   |                      | multiple interventions which                                  |                               |  |           |                  |  |
|                   |                      | en attempted to help ensure                                   |                               |  |           |                  |  |
|                   |                      | R2 himself, were kept safe                                    |                               |  |           |                  |  |
|                   |                      | his escalating behaviors.                                     |                               |  |           |                  |  |
|                   | a protoctou mom      | Totalaming portations.  |                               |  |           |                  |  |
|                   | A Sherburne Count    | y Inmate Locator, printed                                     |                               |  |           |                  |  |
|                   |                      | R2 as a current inmate of the                                 |                               |  |           |                  |  |
|                   |                      | charges listed. These   |                               |  |           |                  |  |

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|  | NT OF DEFICIENCIES<br>OF CORRECTION  |                | R/SUPPLIER/CLIA<br>ATION NUMBER: | , ,            | E CONSTRUCTION                            |           | SURVEY<br>PLETED |  |
|--|--|----------------|----------------------------------|----------------|---|-----------|------------------|--|
| AND FLAIN                                      | OF CORRECTION  | IDENTIFIC      | ATION NOWBER.                    | A. BUILDING:   |   | COIVII    | FLETED           |  |
|  |  |                |                                  |                |   | <b>I</b>  | С                |  |
|  |  | 00614          |                                  | B. WING        |   | 11/       | 18/2020          |  |
| NAME OF  | PROVIDER OR SUPPLIER   |                | STREET AD                        | DRESS, CITY, S | STATE, ZIP CODE                           |           |                  |  |
| TA1 A111                                       | NUIDOINO AND DELLA   | D OFNITED      | 1717 UNI\                        | ERSITY DR      | IVE SOUTHEAST                             |           |                  |  |
| IALAHI   | NURSING AND REHA   | BCENIER        | SAINT CL                         | OUD, MN 50     | 6304                                      |           |                  |  |
| (X4) ID  | SUMMARY STA  | ATEMENT OF DE  | FICIENCIES                       | ID             | PROVIDER'S PLAN OF CORRE                  | CTION     | (X5)             |  |
| PRÉFIX   | (EACH DEFICIENC)   |                |                                  | PREFIX         | (EACH CORRECTIVE ACTION SH                |           | COMPLETE         |  |
| TAG  | REGULATORY OR L  | SC IDENTIFYING | INFORMATION)                     | TAG            | CROSS-REFERENCED TO THE AP<br>DEFICIENCY) | PROPRIATE | DATE             |  |
|  |  |                |                                  |                |   |           |                  |  |
| 2 830  | 0 Continued From page 31   |                |                                  | 2 830          |   |           |                  |  |
|  | charges included a misdemeanor charge for 5th  |                |                                  |                |   |           |                  |  |
|  | degree assault; and  |                |                                  |                |   |           |                  |  |
|  |  |                |                                  |                |   |           |                  |  |
|  | degree criminal sexual conduct. R2's custody date was recorded as 11/6/20, and no bail |                |                                  |                |   |           |                  |  |
|  | amount was posted  |                |                                  |                |   |           |                  |  |
|  | a  |                |                                  |                |   |           |                  |  |
|  | During the abbrevia  | ated survey, f | rom 11/13/20 to                  |                |   |           |                  |  |
|  | 11/18/20, multiple   |                |                                  |                |   |           |                  |  |
|  | interview NP-A regarding R2's behavior and the   |                |                                  |                |   |           |                  |  |
|  | incident which hap   |                |                                  |                |   |           |                  |  |
|  | was found in R1's room sexually assaulting her. A                                      |                |                                  |                |   |           |                  |  |
|  | missed return call v   | was provided   | on 11/18/20, and                 |                |   |           |                  |  |
|  | a message was lef  | t indicating a | telephone                        |                |   |           |                  |  |
|  | interview would not  |                |                                  |                |   |           |                  |  |
|  | 12/2/20, at 1:41 p.r   |                |                                  |                |   |           |                  |  |
|  | verified she helped  |                |                                  |                |   |           |                  |  |
|  | for the duration of h  |                |                                  |                |   |           |                  |  |
|  | NP-A described R2  |                |                                  |                |   |           |                  |  |
|  | often displayed poo  |                |                                  |                |   |           |                  |  |
|  | health. NP-A recall  |                |                                  |                |   |           |                  |  |
|  | 8/27/20, where a st  |                |                                  |                |   |           |                  |  |
|  | voiced R2 was doir   |                |                                  |                |   |           |                  |  |
|  | concerning behaviors was notified on 10/   |                |                                  |                |   |           |                  |  |
|  | laboratory draw and  |                |                                  |                |   |           |                  |  |
|  | ordered clozapine;   |                | _                                |                |   |           |                  |  |
|  | vacation at the time   |                |                                  |                |   |           |                  |  |
|  | updated. NP-A stat   |                |                                  |                |   |           |                  |  |
|  | have re-contacted  |                |                                  |                |   |           |                  |  |
|  | received back as s   |                |                                  |                |   |           |                  |  |
|  | abruptly could dem   | •              |                                  |                |   |           |                  |  |
|  | psychotic symptom  |                |                                  |                |   |           |                  |  |
|  | been off his clozap  |                |                                  |                |   |           |                  |  |
|  | he was arrested. N   |                |                                  |                |   |           |                  |  |
|  | of R2's escalating I   | behaviors afte | er 10/19/20, and                 |                |   |           |                  |  |
|  | voiced had their cli   |                |                                  |                |   |           |                  |  |
|  | have started other   | medications    | as "their were                   |                |   |           |                  |  |
|  | options available."  |                |                                  |                |   |           |                  |  |
|  | antipsychotic medi   |                |                                  |                |   |           |                  |  |
| have side effects which can reduce sexual urge |  |                |                                  |                |   |           |                  |  |

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Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  |   |                             |   | SURVEY<br>PLETED |                          |  |
|--|--|---|-----------------------------|---|------------------|--------------------------|--|
|  |  |   | 7 50.25 10.                 |   | (                | С                        |  |
|  |  | 00614   | B. WING                     |   | 11/1             | 18/2020                  |  |
| NAME OF I  | PROVIDER OR SUPPLIER   |   |                             | STATE, ZIP CODE   |                  |                          |  |
| TALAHI   | NURSING AND REHA   | B CENTER  | IVERSITY DR<br>LOUD, MN  56 | IVE SOUTHEAST<br>6304   |                  |                          |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPF<br>DEFICIENCY) | ULD BE           | (X5)<br>COMPLETE<br>DATE |  |
| 2 830  | Continued From page 32   |   | 2 830                       |   |                  |                          |  |
|  | contribute to those R2 been medicated "helped him to mak potentially not sexu."  A provided Behavio 5/2017, identified a residents who exhibit their physical and policy directed, "Th will address resider comprehensive planisted which directe assessed upon adrochange in condition behaviors and the odeveloped to reduce of behavioral symptomic frequently" in the resident's medical symptomic frequently | y're abruptly stopped it could desires returning, adding had dappropriately it may have to better decisions" and ally assault a female resident. Or Management policy, dated purpose of identifying bit behaviors which decrease asychosocial well-being. The to interdisciplinary team [IDT] in behaviors in the resident's in of care." A procedure was do the resident would be mission, quarterly and upon a for factors which contribute to care plan would then be to eand/or eliminate the cause toms. Further, the policy is residents identified with the sat least quarterly or " deemed necessary by the IDT edical record.  THOD OF CORRECTION: The (DON), or designee, could olicies and procedures on |                             |   |                  |                          |  |
|  | behavioral assessn<br>inservice staff to en<br>worsening behavior<br>ensure ongoing cor  | nent and care planning, then<br>sure the timely assessment of<br>s; then audit resident charts to   |                             |   |                  |                          |  |
| 21375  | MN Rule 4658.0800<br>Program   | 3 Subp. 1 Infection Control;  | 21375                       |   |                  | 12/23/20                 |  |
|  |  | on control program. A nursing<br>sh and maintain an infection   |                             |   |                  |                          |  |

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| Minneso                  | <u>ta Department of He</u>  | alth  |   |                     |  |                               |                          |
|--------------------------|---|---|---|---------------------|--|-------------------------------|--------------------------|
|                          | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |   |   |                     | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                          |
|                          |   | 00614   |   | B. WING             |  | 11/1                          | 8/2020                   |
| NAME OF F                | PROVIDER OR SUPPLIER  |   | STREET AD   | DRESS, CITY, S      | STATE, ZIP CODE  |                               |                          |
| TAL ALL                  | NURSING AND REHA  | D CENTED  | 1717 UNI\   | ERSITY DR           | IVE SOUTHEAST  |                               |                          |
| IALAHII                  | NORSING AND KENA  | D CENTER  | SAINT CL  | OUD, MN 5           | 6304   |                               |                          |
| (X4) ID<br>PREFIX<br>TAG | SUMMARY STA<br>(EACH DEFICIENCY<br>REGULATORY OR L  |   | EDED BY FULL  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE                          | (X5)<br>COMPLETE<br>DATE |
| 21375                    | Continued From pa   | ge 33   |   | 21375               |  |                               |                          |
|                          | control program designed to provide a safe and sanitary environment.  |   |   |                     |  |                               |                          |
|                          | This MN Requirement   |   |   |                     |  |                               |                          |
|                          | Based on observation review, the failed to environmental clear procedures according manufacturer's instruction of infection transmitted the facility. In additional staff correctly were (PPE) during daily residents (R4 and Exprecautions and the hygiene while work R6, and R7) rooms service in the memory care in the memory care unit. R17, R18) eating dispersional control of the footbase and the time of the footbase according to the footbase of the footbase of the failed to ensure the failed to ensure the footbase of the footbase of the footbase of the failed to ensure the | ensure staffining and dising and dising to the dising ructions to describe the fact all 57 resident of the facility personal protoom cleaning (A7) observed at staff performand during dory care unitatined for 1 R12, R13, Ruring meal set of this had the redictions of the fact of the | followed infection infectant ecrease the risk acility. This had dents residing in ty failed to ensure stective equipment g for 2 of 2 in droplet emed hand resident (R4, R5, dining room meal Lastly, the all dining room ist 6 feet between 1 of 12 residents 14, R15, R16, ervice in the potential to affect nemory care unit |                     | Corrected  |                               |                          |
|                          | Findings include:   | 0.54  | /OUTN 110 * :   |                     |  |                               |                          |
|                          | ENVIRONMENTAL<br>USE/PPE USE  | . CLEANING/   | CHEMICAL  |                     |  |                               |                          |
|                          | A facility provided E<br>R4 and R7 required<br>droplet precautions  | l 14 day adm  |   |                     |  |                               |                          |
|                          | During observation  | on 11/18/20,  | at 9:14 a.m. the  |                     |  |                               |                          |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  |   | TIPLE CONSTRUCTION  NG:                         |   | (X3) DATE SURVEY<br>COMPLETED        |                          |
|--|--|---|---|---|--------------------------------------|--------------------------|
|  |  | 00614   | B. WING   |   |                                      | C<br><b>18/2020</b>      |
| NAME OF  | PROVIDER OR SUPPLIER   | :   | STREET ADDRESS, CIT                             | Y, STATE, ZIP CODE  |                                      |                          |
|  |  |   | 1717 UNIVERSITY                                 | DRIVE SOUTHEAST   |                                      |                          |
| IALAHI   | NURSING AND REHA   | BCENIER   | SAINT CLOUD, MN                                 | 56304   |                                      |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FI<br>SC IDENTIFYING INFORMAT   |   | PROVIDER'S PLAN (<br>(EACH CORRECTIVE A<br>CROSS-REFERENCED TO<br>DEFICIE | CTION SHOULD BE<br>O THE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| 21375  | Continued From pa  | ge 34   | 21375   |   |                                      |                          |
| 21375  | Westwood Lane ha R7) doors that direct droplet precautions personal protective sanitizer was access located just outside  On 11/18/20, during 9:39 a.m. houseked enter R4's room aft performing hand hy R4's room with the small trash can of u contents of can into uncovered garbage with the same liner time, H-A's gown w the front of the gow gown ties made mu floor as she bent ov H-A exited the room in the hallway, and housekeeping cart hand hygiene.  - At 9:45 a.m. h R6's room, and clea furniture with a wet 9:53 a.m., removed paper from the cart to another resident' did not perform har - At 9:54 a.m. h grab both handles of outside of R7's room side of R7's hallway moved a black bas on the wheeled wal underneath the wal | de signs on two resider cted R4 and R7 were of along with directions equipment (PPE) use sible on top of isolation of R4 and R7's doorwer continued observation of R4 and R7's doorwer donning PPE and orgiene. At 9:41 a.m. Hasame PPE on and carried gowns and dump of the housekeeping carried and returned the gard back into R4's room. At 9:43 a.m. the unfolding the direct contacts were to clean R4's wheem, removed gown and disposed of them in the garbage. H-A did not got along the direct contacts were to clean R4's wheem, removed gown and disposed of them in the garbage. H-A did not got along the direct contacts were to clean R4's wheem, removed gown and disposed of them in the garbage. H-A did not got along the direct contacts were to clean R4's wheem, removed gown and disposed of them in the garbage. H-A did not got along the tray table rag. H-A exited R6's read hygiene after glove H-A used non-gloved her and moved it to the weight of the total contact of the second response to the second response | ont (R4, on for . Hand n bins vays. on at ed to |   |                                      |                          |

Minnesota Department of Health

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X2) MULTIPL<br>A. BUILDING:                  | E CONSTRUCTION |                | (X3) DATE SURVEY<br>COMPLETED                          |                 |                  |
|---|---|---|----------------|----------------|--|-----------------|------------------|
|   |   |   |                |                |  |                 | С                |
|   |   | 00614   |                | B. WING        |  |                 | 18/2020          |
| NAME OF   | PROVIDER OR SUPPLIER                            |   | STREET AD      | DRESS, CITY, S | STATE, ZIP CODE  |                 |                  |
| <b>TALAI</b>  | NUIDOINO AND DELLA                              | D OFWED                                       | 1717 UNI       | VERSITY DR     | IVE SOUTHEAST  |                 |                  |
| IALAHI  | NURSING AND REHA                                | BCENIER                                       | SAINT CL       | OUD, MN 5      | 6304   |                 |                  |
| (X4) ID   | SUMMARY STA                                     | TEMENT OF DEFICIENC                           | IES            | ID             | PROVIDER'S PLAN O                                      | F CORRECTION    | (X5)             |
| PREFIX<br>TAG   |   | ' MUST BE PRECEDED E<br>SC IDENTIFYING INFORI |                | PREFIX<br>TAG  | (EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIEN | THE APPROPRIATE | COMPLETE<br>DATE |
| 21375   | Continued From pa                               | ge 35   |                | 21375          |  |                 |                  |
|   | with a dry cloth. H-A                           |   |                |                |  |                 |                  |
|   | hygiene after. Imme                             |   |                |                |  |                 |                  |
|   | walker, H-A stated<br>Sani-Clean 2. H-A         |   |                |                |  |                 |                  |
|   | was sprayed on sur                              |   |                |                |  |                 |                  |
|   | minutes" before bei                             |   | 3 10 10        |                |  |                 |                  |
|   |   | H-A donned gloves                             | without        |                |  |                 |                  |
|   | having performed h                              |   |                |                |  |                 |                  |
|   | room without having                             |   |                |                |  |                 |                  |
|   | grabbed a small ga                              |   |                |                |  |                 |                  |
|   | dumped the contents of the garbage can into the |   |                |                |  |                 |                  |
|   | housekeeping cart's                             | •   | •              |                |  |                 |                  |
|   | placed H-A in the m                             |   |                |                |  |                 |                  |
|   | returned the can ba                             |   |                |                |  |                 |                  |
|   | a.m. H-A opened R<br>gloved hand, turned        |   |                |                |  |                 |                  |
|   | approached R7's de                              |   |                |                |  |                 |                  |
|   | mug, and brought t                              |   |                |                |  |                 |                  |
|   | room with the old m                             |   |                |                |  |                 |                  |
|   | corner of the house                             |   |                |                |  |                 |                  |
|   | multiple cloth mop I                            |   |                |                |  |                 |                  |
|   | cart with a gloved h                            | and; however did r                            | ot pick one    |                |  |                 |                  |
|   | up. Instead, she do                             |   |                |                |  |                 |                  |
|   | failed to perform ha                            |   |                |                |  |                 |                  |
|   | across the hall to R                            |   |                |                |  |                 |                  |
|   | having touched R6'                              |   |                |                |  |                 |                  |
|   | exited R6's room w                              |   |                |                |  |                 |                  |
|   | H-A cleaned R6's to                             |   |                |                |  |                 |                  |
|   | chemical to sit prior                           |   | •              |                |  |                 |                  |
|   | multiple clean dry c                            | •   |                |                |  |                 |                  |
|   | gloved hands once                               |   |                |                |  |                 |                  |
|   | wiped down most the                             |   |                |                |  |                 |                  |
|   | wet rag; however, f                             | ailed to wipe down                            | the sink.      |                |  |                 |                  |
|   | Again, H-A touched                              |   |                |                |  |                 |                  |
|   | cart with her gloved                            |   |                |                |  |                 |                  |
|   | R7's bathroom, clea                             |   |                |                |  |                 |                  |
|   | designated glass cl                             |   |                |                |  |                 |                  |
|   | same glass cleaner                              |   |                |                |  |                 |                  |
|   | 10:01 a.m. H-A tou                              | ched a stack of clea                          | an rad and     |                |  |                 | 1                |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X2) MULTIPL<br>A. BUILDING:   | E CONSTRUCTION   |                     | (X3) DATE SURVEY<br>COMPLETED  |             |                          |
|---|---|--|--|---------------------|--|-------------|--------------------------|
|   |   | 00614  |  | B. WING             |  |             | C<br><b>18/2020</b>      |
| NAME OF I   | PROVIDER OR SUPPLIER  |  | STREET AD  | DRESS, CITY, S      | STATE, ZIP CODE  |             |                          |
| TALAHI  | NURSING AND REHA  | B CENTER   |  |                     | IVE SOUTHEAST  |             |                          |
|   |   |  |  | OUD, MN 50          |  |             |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY  | TEMENT OF DEFICIEN<br>MUST BE PRECEDED<br>SC IDENTIFYING INFOR   | BY FULL  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTIOI<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | N SHOULD BE | (X5)<br>COMPLETE<br>DATE |
| 21375   | Continued From pa   | ge 36  |  | 21375               |  |             |                          |
|   | R5's room and spra<br>cleaner onto R5's w<br>right away after app   | trag to clean off to the trag to clean off to the trag to have and the trag to the trag trag trag trag trag trag trag trag   | he light in proached with use. H-A nished a gown at proached to perform water mug to giene after es, entered tion foaming he wiped off   |                     |  |             |                          |
|   | On 11/18/20, at 10: observation H-A ho to exit R7's room af with a carpet cleane hallway to a housek returned with more gown on and no glo waist were not tied uniform back. H-A room with the gown hygiene, and prepp At 10:21 a.m. H-A esection where R5 w 2 feet from her whe wheelchair, brough removed the gown the hallway to the h the housekeeping refeet from the cart at Lane. H-A failed to gown removal. Afte sections of the gow the top of the garbar | usekeeper H-A water having washed a rand proceeded deeping room whe cleaner solution. It was the gown ties which exposed the stepped a few feed the cleaner for the cleaner fo | as observed of the carpet down the re she H-A had a se at H-A's et into R5's orm hand roperation. It is main living cliner, about oed R5's lway, and walk down located by the gown in oximately 3 estwood giene after the garbage, sed above |                     |  |             |                          |

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Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | ` ′   | E CONSTRUCTION   | (X3) DATE           | SURVEY   |   |                |
|---|---|---|--|---------------------|--|---|----------------|
| ,   | 0. 0020   |   |  | A. BUILDING:        | <del></del>  |   |                |
|   |   | 00614   |  | B. WING             |  | 1 | 8/ <b>2020</b> |
| NAME OF   | PROVIDER OR SUPPLIER  |   | STREET AD  | DRESS, CITY, S      | STATE, ZIP CODE  |   |                |
| TALALI  | NUIDCING AND DELLA  | D CENTED  | 1717 UNI   | ERSITY DR           | IVE SOUTHEAST  |   |                |
| ІАСАПІ  | NURSING AND REHA  | ID CENTER   | SAINT CL   | OUD, MN 50          | 6304   |   |                |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STA<br>(EACH DEFICIENC)<br>REGULATORY OR L  |   | EDED BY FULL   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY) |   |                |
| 21375   | Continued From pa   | ige 37  |  | 21375               |  |   |                |
| 21375   | end of the garbage - At 10:22 a.m. proceeded to touch cleaned the carpet: foot board and cove pockets. At 10:29 a carpet, turned off the exited R5's room. In hygiene after exitin  When interviewed a stated she was requentered a resident precaution signage not tied the gown of R4 and R7's rooms the required PPE with H-A acknowledged incorrect glove use when she worked be rooms, along with In R4 and R7 out in the on the gowns did n had not updated he voiced if the gown of was a risk of "poter around" the room. If orgotten to put the room and voiced sl | can. H-A entered In the following R5's walker, ering, door ed a.m. H-A finish the light by the H-A failed to progress of the numerous and that she when in R7's rotthe numerous and lack of his etween R4, | items as she tray table, bed ge, her uniform hed cleaning the doorway, and erform hand  at 10:29 a.m. H-A PPE when she ted with droplet ledged she had she worked in did not wear all bom. Further, is episodes of and hygiene 25, R6, and R7's are gown used in A stated the ties me" and that she about this. H-A ne floor there nating things she had reto entering R7's e worn it; | 21375               |  |   |                |
|   | however, stated sh<br>actions impacted o  | ther residents  | as she was "just   |                     |  |   |                |
|   | doing the bathroom  | of what the w   | ord droplet  |                     |  |   |                |
|   | meant for droplet p   | erform hand hy  | ygiene before  |                     |  |   |                |
|   | entering and after entering before she touched  |   |  |                     |  |   |                |
|   | touched potentially   |   |  |                     |  |   |                |
|   | H-A explained she when cleaning and   | was expected  | to wear gloves   |                     |  |   |                |

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| MILLINESC    | ita Department of He  | aim   |              |   |           |                  |
|--------------|-----------------------|---|--------------|---|-----------|------------------|
| STATEMEN     | NT OF DEFICIENCIES    | (X1) PROVIDER/SUPPLIER/CLIA                           | (X2) MULTIPL | E CONSTRUCTION                                | (X3) DATE | SURVEY           |
| AND PLAN     | OF CORRECTION         | IDENTIFICATION NUMBER:                                | A. BUILDING: |   | COMPI     | LETED            |
|              |                       |   |              |   |           |                  |
|              |                       |   | D WING       |   | C         |                  |
|              |                       | 00614   | B. WING      |   | 11/1      | 8/2020           |
| NAME OF F    | PROVIDER OR SUPPLIER  | STREET AD   | DRESS CITY S | STATE, ZIP CODE                               |           |                  |
| TW WILL OF T | NOVIDEN ON OUT LIEN   |   | , ,          | ,   |           |                  |
| TALAHI       | NURSING AND REHA      | B CENTER  |              | IVE SOUTHEAST                                 |           |                  |
|              |                       | SAINT CL  | OUD, MN 50   | 6304  |           |                  |
| (X4) ID      |                       | TEMENT OF DEFICIENCIES                                | ID           | PROVIDER'S PLAN OF CORRECTION                 |           | (X5)             |
| PREFIX       |                       | / MUST BE PRECEDED BY FULL                            | PREFIX       | (EACH CORRECTIVE ACTION SHOUL                 |           | COMPLETE<br>DATE |
| TAG          | REGULATORY OR L       | SC IDENTIFYING INFORMATION)                           | TAG          | CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | TRIATE    | DAIL             |
|              |                       |   |              | 22.16.2.16.1                                  |           |                  |
| 21375        | Continued From pa     | ge 38   | 21375        |   |           |                  |
|              | •                     |   |              |   |           |                  |
|              |                       | g items on her cart. In                               |              |   |           |                  |
|              |                       | d she was further expected to                         |              |   |           |                  |
|              |                       | ly inside a resident room and                         |              |   |           |                  |
|              | •                     | s were not to be worn in the                          |              |   |           |                  |
|              |                       | lly, H-A stated she should not                        |              |   |           |                  |
|              |                       | wn haphazardly in the cart                            |              |   |           |                  |
|              | garbage as this sho   | ould have been removed                                |              |   |           |                  |
|              | before she exited R   | R7's room and disposed of                             |              |   |           |                  |
|              | correctly. H-A voice  | ed she had never been told she                        |              |   |           |                  |
|              | was to tie the garba  | age bags in the residents room                        |              |   |           |                  |
|              | before exiting the ro | oom; however, did state this                          |              |   |           |                  |
|              |                       | actice as "it could be                                |              |   |           |                  |
|              |                       | explained she had used a                              |              |   |           |                  |
|              |                       | vel cleaner to clean R7's toilet.                     |              |   |           |                  |
|              |                       | ufacturer recommendation for                          |              |   |           |                  |
|              |                       | minutes; however, H-A                                 |              |   |           |                  |
|              |                       | east 5." H-A stated she used                          |              |   |           |                  |
|              |                       | Cleaner in R7's bathroom and                          |              |   |           |                  |
|              |                       | using this on the sink. H-A                           |              |   |           |                  |
|              |                       | aner was to only be used on                           |              |   |           |                  |
|              |                       | she should have used                                  |              |   |           |                  |
|              |                       | e sink instead. H-A read the                          |              |   |           |                  |
|              |                       | of the Sani-Clean and                                 |              |   |           |                  |
|              |                       | remain on a surface wet for                           |              |   |           |                  |
|              |                       | knowledged incorrect use of                           |              |   |           |                  |
|              |                       | the therapy wheeled walker. In                        |              |   |           |                  |
|              |                       | d she had not received training                       |              |   |           |                  |
|              |                       | •   |              |   |           |                  |
|              |                       | he was expected to use;<br>to keep things cleaned the |              |   |           |                  |
|              | best she can.         | to keep triings cleaned trie                          |              |   |           |                  |
|              | best sile call.       |   |              |   |           |                  |
|              | During intensions on  | 11/18/20 at 11:05 a m                                 |              |   |           |                  |
|              |                       | 11/18/20, at 11:05 a.m.                               |              |   |           |                  |
|              |                       | ctor (HD) stated Sani-Clean 2                         |              |   |           |                  |
|              |                       | nical used for cleaning in the                        |              |   |           |                  |
|              |                       | n resident bathrooms. HD                              |              |   |           |                  |
|              |                       | ess when she used Sani-Clean                          |              |   |           | <b>]</b>         |
|              |                       | a surface, let it sit for two to                      |              |   |           | <b>]</b>         |
|              |                       | then wipe it off "a little bit" so                    |              |   |           |                  |
|              |                       | vever, HD acknowledged the                            |              |   |           |                  |
|              | manufacturer instru   | ictions were for it to stay wet                       |              |   |           |                  |

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| Minneso       | <u>ota Department of He</u> | ealth ealth   |               |   |           |                  |
|---------------|-----------------------------|---|---------------|---|-----------|------------------|
|               | NT OF DEFICIENCIES          | (X1) PROVIDER/SUPPLIER/CLIA                                 | (X2) MULTIPL  | LE CONSTRUCTION   | (X3) DATE |                  |
| AND PLAN      | OF CORRECTION               | IDENTIFICATION NUMBER:                                      | A. BUILDING:  |   | COMPI     | _E I E D         |
|               |                             |   |               |   | l c       | ;                |
|               |                             | 00614   | B. WING       |   | 1         | 8/2020           |
| NAME OF I     |                             | CTDEET AD   | DDECC CITY (  | CTATE ZID CODE  | <u> </u>  |                  |
| NAME OF 1     | PROVIDER OR SUPPLIER        |   |               | STATE, ZIP CODE   |           |                  |
| TALAHI        | NURSING AND REHA            | AR CENTED   |               | RIVE SOUTHEAST  |           |                  |
|               | Г                           |   | OUD, MN 50    |   |           |                  |
| (X4) ID       |                             | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL          | ID            | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL |           | (X5)<br>COMPLETE |
| PREFIX<br>TAG |                             | SC IDENTIFYING INFORMATION)                                 | PREFIX<br>TAG | CROSS-REFERENCED TO THE APPROI                              |           | DATE             |
|               |                             |   |               | DEFICIENCY)   |           |                  |
| 21375         | Continued From pa           | 20.30   | 21375         |   |           |                  |
| 21010         | -                           |   |               |   |           |                  |
|               |                             | r 10 minutes. HD explained her                              |               |   |           |                  |
|               |                             | re it on the surfaces that long                             |               |   |           | ı                |
|               |                             | king around." HD stated                                     |               |   |           | ı                |
|               |                             | used an instant action                                      |               |   |           | ı                |
|               | foaming cleaner for         |   |               |   |           | ı                |
|               |                             | not used on. HD explained the                               |               |   |           | ı                |
|               |                             | vere to keep on surfaces for                                |               |   |           |                  |
|               |                             | owever, when the can was ructions directed for staff to let |               |   |           | ı                |
|               |                             | HD explained her staff did not                              |               |   |           | ı                |
|               |                             | ne to let it sit on surfaces for                            |               |   |           | ı                |
|               |                             | owledged staff were expected                                |               |   |           | ı                |
|               |                             | facturer instructions for use;                              |               |   |           | ı                |
|               |                             | d due to work load and the                                  |               |   |           | ı                |
|               |                             | eeping staff available, if staff                            |               |   |           | ı                |
|               |                             | facture instructions for                                    |               |   |           | ı                |
|               |                             | ld not get all of their required                            |               |   |           | ı                |
|               |                             | pleted each day. HD denied                                  |               |   |           | ı                |
|               |                             | sations with the current                                    |               |   |           | ı                |
|               |                             | ut the cleaning instruction time                            |               |   |           | ı                |
|               |                             | the chemicals used in the                                   |               |   |           | ı                |
|               |                             | nousekeeping staff were                                     |               |   |           | ı                |
|               |                             | all PPE as instructed, which                                |               |   |           | ı                |
|               |                             | d inside the residents room and                             |               |   |           | ı                |
|               |                             | ne room. Further, HD explained                              |               |   |           |                  |
|               |                             | to wear gloves and perform                                  |               |   |           | ı                |
|               | , , ,                       | irected. In addition, HD stated                             |               |   |           | ı                |
|               |                             | sekeeping staff to dispose of                               |               |   |           | ı                |
|               |                             | nd to dispose of used PPE<br>g the bag from the trash can   |               |   |           | ı                |
|               |                             | garbage bag in the cart trash.                              |               |   |           | ı                |
|               |                             | aff did not follow infection                                |               |   |           | ı                |
|               |                             | s directed she "would think that                            |               |   |           |                  |
|               | •                           | on control issue as you have                                |               |   |           | ı                |
|               |                             | exposed all those people to                                 |               |   |           | ı                |
|               |                             | everyone could be sick." HD                                 |               |   |           | ı                |
|               |                             | rformed any recent audits as                                |               |   |           | ı                |
|               |                             | e the time" to do them or "follow                           |               |   |           |                  |
|               |                             | D explained her staff had been                              |               |   |           | ı                |
|               |                             | i-Clean approximately five                                  |               |   |           |                  |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION   |                           |  | (X3) DATE SURVEY<br>COMPLETED |                          |
|---|--|--|---------------------------|--|-------------------------------|--------------------------|
| ,   | o. oo2011011   |  | A. BUILDING:              |  |                               |                          |
|   |  | 00614  | B. WING                   |  |                               | C<br>1 <b>8/2020</b>     |
| NAME OF   | PROVIDER OR SUPPLIER   | STREET AD  | DRESS, CITY, S            | STATE, ZIP CODE  |                               |                          |
| TALAHI  | NURSING AND REHA   | AR CENTER  | /ERSITY DR<br>.OUD, MN 50 | IVE SOUTHEAST<br>6304  |                               |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHOI<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | JLD BE                        | (X5)<br>COMPLETE<br>DATE |
| 21375   | months ago; howey document any train. When interviewed director of nursing does all the cleaning expected to follow as the facility used products. Further, twere expected to pwear PPE as direct removed prior to export to expected to pwear expected to expect to expect as direct removed prior to expect as disposed of also stated if staff were guidelines there was "spread infection to "Let solution remain 10 minutes. Rinse and A Rest Stop restroct information sheet, to toilet bowls were claremain on surface minutes; then flush A ZenaCrystal glass information sheet, clean mirrors, wind other glass surface than D HYGIENE.  During a continued | ver, stated she does not ing.  on 11/18/20, at 2:08 p.m. the (DON) stated housekeeping ing; however, all staff were the manufacturer instructions a "variety" of cleaning the DON explained all staff erform hand hygiene and to sted, that gowns were to be citing resident rooms identified sed precautions, and that PPE is as a directed. The DON not following infection control in a potential for them to be residents and staff."  Inufacturer label, undated disinfecting and cleaning to, in on surface for a minimum of or allow to air dry."  In disinfectant manufacturer undated instructed staff when eaned to, "Allow product to for a contact time of 10 toilet."  Is cleaner manufacturer undated, indicated, "use to ows, automotive glass, and | 21375                     |  |                               |                          |
|   |  | eeding R8 and R9. At 1:11  |                           |  |                               |                          |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:   |  |                          | (X3) DATE SURVEY<br>COMPLETED  |                               |                          |
|---|--|--|--|--------------------------|--|-------------------------------|--------------------------|
|   |  |  |  | 7 t. BOILBIITO.          |  |                               | _                        |
|   |  | 00614  |  | B. WING                  |  |                               | C<br>1 <b>8/2020</b>     |
| NAME OF   | PROVIDER OR SUPPLIER   |  | STREET AD  | DRESS, CITY, S           | STATE, ZIP CODE  |                               |                          |
| TALAHI  | NURSING AND REHA   | B CENTER   |  | /ERSITY DR<br>OUD, MN 50 | IVE SOUTHEAST<br>6304  |                               |                          |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STA<br>(EACH DEFICIENCY<br>REGULATORY OR L   |  | EDED BY FULL   | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTIC<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | ON SHOULD BE<br>E APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| 21375   | p.m. NA-D fed R8 a designated hand fo R9's hands as she liquid. At 1:14 p.m. plate of R9. At 1:16 with a napkin using silverware with her R9. NA-D did not pour these observations - At 1:18 p.m. No carrying a resident metal cart of other sat next to R8 and At 1:19 a.m. NA-C his wheelchair, silve his hand. Immediate R11 and touched R of food. Immediatel R8, touched her ow picked up R8's silve hand hygiene durin | and R9 without reach reside assisted her to NA-D touched p.m. NA-D wher right hand right hand, are form hand how the residence of the reach took over assupproached Forware, and pely after, NA-C after, NA-C after, NA-C and then fed and then fed and then fed and then fed and the metal on the metal on the metal on the metal on the metal cked up the cay from the ty in the metal on th | nt. NA-D touched to hold a glass of d the divided viped R8's face and, picked up R9's and started to feed by giene during the dining room d placed it in a ays. After, NA-C sisting R8 to eat. R10 and touched placed a cup in C walked over to d fed her a bite a walked back to e sat down, and a did not perform a rvations. I her face mask R9 using the walked over to offee and table. As she I container, she tray onto the cups, she walked e she handed e TV remote. Cup. NA-D did these cup immediately rinking, NA-C clothing hing protector to | 21375                    |  |                               |                          |

Minnesota Department of Health

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTIPLI<br>A. BUILDING:   | E CONSTRUCTION      |  | (X3) DATE SURVEY<br>COMPLETED |                          |
|--|---|---|---------------------|--|-------------------------------|--------------------------|
|  |   | 00614   | B. WING             |  | l l                           | C<br><b>18/2020</b>      |
|  | PROVIDER OR SUPPLIER  | B CENTER 1717 UN  |                     | TATE, ZIP CODE  VE SOUTHEAST  3304   |                               |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>'MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | N SHOULD BE                   | (X5)<br>COMPLETE<br>DATE |
| 21375  | with bare hands to own hair, took off a protector and place metal cart. At 1:31 belt on R10 and tra NA-C did not perfor observations.  During observation to be absent from the dining room, had have required staff to sanitize frequents.  During interview on stated hand hygiene during observations.  During interview on stated hand hygiene during observation was a stated not performing required times risks.  When interviewed on NA-D stated hand hand after resident control resident to eat, "before everything." NA-D awashed her hands in the dining room; performed hand hygiene during observations." | lift it. After, NA-C touched her nother resident's clothing d the remaining trays in the p.m. NA-C placed a transfer nsferred him to a recliner. Im hand hygiene during these hand sanitizer was observed the dining room tables. The litizer station was just inside nging on the wall which would to get up through out the mea |                     |  |                               |                          |
|  | DON stated she wo   | ould expect hand hygiene to be physical contact with a  |                     |  |                               |                          |

Minnesota Department of Health

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Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | ` ′  | E CONSTRUCTION  |                          | (X3) DATE SURVEY<br>COMPLETED   |                                      |                          |
|--|--|--|---|--------------------------|---|--------------------------------------|--------------------------|
|  |  | 00614  |   | B. WING                  |   |                                      | C<br>1 <b>8/2020</b>     |
| NAME OF I  | PROVIDER OR SUPPLIER   |  | STREET AD   | DRESS, CITY, S           | STATE, ZIP CODE   | ·                                    |                          |
| TALAHI   | NURSING AND REHA   | B CENTER   |   | /ERSITY DR<br>OUD, MN 50 | IVE SOUTHEAST<br>6304   |                                      |                          |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STA<br>(EACH DEFICIENCY<br>REGULATORY OR L   |  | DED BY FULL   | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN O<br>(EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIEN | CTION SHOULD BE<br>) THE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| 21375  | Continued From pa  | ge 43  |   | 21375                    |   |                                      |                          |
|  | resident. The DON following infection of potential for them to and staff."   | l explained if st<br>control guidelin  | es there was a  |                          |   |                                      |                          |
|  | COMMUNAL DININ   | NG:  |   |                          |   |                                      |                          |
|  | During observation residents were sear memory care dining six feet of at least oresidents in the me R9, R10, R11, R12 R18) except for R12 approximately 3 feet the only resident obdistanced at 6 feet room floors or table indicators of placer social distancing wano indicators to direct on 11/28/20, at 1:1 enter the dining room R8, where NA-C wand NA-D and R9, and eating. NA-D continuations was a simple continuation.  | ted around 6 tag room. Each tag room. Each tag room. Each tag room, Each tag room, R13, R14, R19 were observed to be served to see the served to see the served to see the served to be served to be served to be served to see the served to see the served to see the served to see the served to assistanted to assissanted to assistanted to assistanted to assistanted to assistant | ables in the able was within tent table. All ing room (R8, 15, R16, R17, ed to be her. R19 was socially ine. The dining visible is to ensure and there were dent placement.  Vas observed to the right side of icross from it R8 with |                          |   |                                      |                          |
|  | During interview on stated knowledge of distancing guideline typically sat in the showever, voiced with spread the resident attempted to place during the noon mespread out. NA-C awere not socially distance of the statement of t | of communal di<br>es. NA-C expla<br>eame spot each<br>th COVID-19 th<br>es out. NA-C de<br>residents at dif<br>eal or encourage<br>acknowledged  | ning social ined residents n meal; ne staff try to enied she fferent spots jed them to the residents  |                          |   |                                      |                          |

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| Minneso                  | <u>ta Department of He</u>  | alth  |   | _                            |  |                               |                          |
|--------------------------|---|---|---|------------------------------|--|-------------------------------|--------------------------|
|                          | NT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER<br>IDENTIFICA   | /SUPPLIER/CLIA<br>TION NUMBER:  | (X2) MULTIPL<br>A. BUILDING: | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                          |
|                          |   | 00614   |   | B. WING                      |  | C<br>11/18/2020               |                          |
| NAME OF F                | PROVIDER OR SUPPLIER  |   | STREET AD   | DRESS CITY S                 | STATE, ZIP CODE  | •                             |                          |
|                          |   |   |   |                              | IVE SOUTHEAST  |                               |                          |
| TALAHI                   | TALAHI NURSING AND REHAB CENTER SAINT C   |   |   |                              | 6304   |                               |                          |
| (X4) ID<br>PREFIX<br>TAG | SUMMARY STA<br>(EACH DEFICIENCY<br>REGULATORY OR L  |   | EDED BY FULL  | ID<br>PREFIX<br>TAG          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE                          | (X5)<br>COMPLETE<br>DATE |
| 21375                    | Continued From pa   | ge 44   |   | 21375                        |  |                               |                          |
|                          | however, explained<br>enough room to ma<br>residents eating in t  | she did not fo<br>iintain social c  | listancing for all  |                              |  |                               |                          |
|                          | When interviewed of NA-D stated knowled social distancing gut "We try our best to hard." Further, NA-I required feeding as residents to social of them at the same to have three aides be acknowledged their distanced during the had attempted to plispots during the messpread out.                     | edge of commidelines. NA-l social distance D explained the sistance were distances as "me" and "we cack here." NA-residents were acce residents                           | unal dining D explained, e but it is very he residents who the hardest we have to feed do not always D e not socially and denied she at different   |                              |  |                               |                          |
|                          | During interview on registered nurse (R communal dining so RN-C voiced he had around 12:30 p.m. I social distancing iss stated he did not se RN-C had not been were present in the were seated during RN-C had been ver residents' seated parabolic observation, RN-C resident had not maduring the meal. | N)-C stated kercial distancing entered the chat afternoon sues during the concerns at able to recall dining room of RN-C's obserbally updated attern during tacknowledged | nowledge of<br>g guidelines.<br>dining room<br>to observe for<br>e noon meal and<br>t that time.<br>which residents<br>or where they<br>rvation. After<br>on the<br>he 1:08 p.m.<br>d all but one |                              |  |                               |                          |
|                          | On 11/28/20, surve<br>notes did not reflect<br>room from 1:08 p.m   | RN-C enterir  | ng the dining   |                              |  |                               |                          |

Minnesota Department of Health

When interviewed on 11/28/20, at 2:08 p.m. the

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|   |   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                       | E CONSTRUCTION   |                                   | (X3) DATE SURVEY<br>COMPLETED |  |  |
|---|---|---|-----------------------|--|-----------------------------------|-------------------------------|--|--|
|   |   |   | A. BUILDING.          |  |                                   | С                             |  |  |
|   | 00614   |   | B. WING               |  |                                   | 18/2020                       |  |  |
| NAME OF PROVIDER OR SUPPLIER STREET   |   |   | DRESS, CITY, S        | STATE, ZIP CODE  |                                   |                               |  |  |
| TALAHI NURSING AND REHA   |   | /ERSITY DR<br>.OUD, MN 50   | IVE SOUTHEAST<br>6304 |  |                                   |                               |  |  |
| (X4) ID SUMMARY STA<br>PREFIX (EACH DEFICIENC'<br>TAG REGULATORY OR L   |   | EDED BY FULL  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETE<br>DATE      |  |  |
| DON stated she ex social distancing of during meals. The observed the dining some time" and har regarding staff condistancing. The DO recliners and chairs help ensure social however, she voice around." The DON have been taken to the dining room for "We have talked al staff were not follow guidelines there was "spread infection to "spread infection to shields." Further, the following: "PPE is rooms and removation is solation rooms;" given handling items that when entering isolation designated clear leaving a treatment hands after removing the gown and leaving the treatment directed when applicompletely covered. | spected staff to at least 6 feet DON explained groom during do not been away cerns in regard to the memoral stancing in the distancing infection as a potential or residents and so residents and so residents and so residents and so required for eral is required proves should be may be contacted in areas; and reat area; immediation areas; do a reas and reat area; immediation areas; do a read areas; immediation areas; do a read areas; immediation areas; do a read areas and reat area; immediation areas; do a read area; immediation area; do a read area; immediation area; do a read area; immediation area; do a read area; | et was maintained ed she had not y a meal "for ware of issues rds to social f have moved ory care unit to the lounge areas; a get moved ecific actions al distancing in ver, she stated, DON explained if control for them to d staff."  ive Equipment, includes gloves, ear, and face tified the intry into isolation orior to leaving one worn when aminated and on not wear gloves emove before liately wash d glove use does is will be applied and should not be gowns should be not of the person emoved before didition, the policy in all clothing is | 21375                 |  |                                   |                               |  |  |

Minnesota Department of Health

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:  |                        |                         | (X3) DATE SURVEY<br>COMPLETED   |                                 |                          |
|--|---|---|------------------------|-------------------------|---|---------------------------------|--------------------------|
|  | 00614   |   |                        | B. WING                 |   |                                 | C<br><b>18/2020</b>      |
| NAME OF  | PROVIDER OR SUPPLIER  |   |                        |                         | STATE, ZIP CODE   |                                 | 10/2020                  |
| I TALAHINURSING AND REHAB CENTER   |   |   |                        | ERSITY DR<br>DUD, MN 56 | IVE SOUTHEAST<br>3304   |                                 |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   |                        | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO TO<br>DEFICIENC' | ION SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| 21375  | Continued From pa   | ge 46   |                        | 21375                   |   |                                 |                          |
|  | instructed hand hyg<br>before applying glow<br>their removal, after<br>were handled, and a<br>objects in the immed.  A facility policy Clean<br>Resident Rooms of<br>Suspected/Confirm<br>indicated staff were<br>instructions for all contact time, et<br>environmental servicular hands often, in<br>glowe removal and in<br>staff should wear di | d Hygiene, revised 9/17/20 giene was to be performed wes or other PPE and after potentially contaminated it after contact with inanimated it after contact with inanimated it after vicinity of a resident. It aming and Disinfection of a facility areas of ed COVID-19, dated 6/23/20 to follow the manufacture leaning and disinfection intration, application method ic. Further, the policy directices staff and others should including immediately after that environmental service is sposable gloves and gowreaning process, including | r tems tee             |                         |   |                                 |                          |
|  | identified, "Commun<br>COVID-19 negative<br>only), residents may<br>social distancing. Li<br>based on COVID-19<br>Further, the policy in<br>remain 6 ft [feet] ap<br>SUGGESTED MET<br>director of nursing (<br>review applicable por<br>COVID-19; then ed<br>adequate social dis<br>procedures to preve   | policy, revised 10/19/20 nal dining limited (for or asymptomatic resident y eat in the same room wit imitations will be considered infections in the facility." dentified, "Residents showert if in communal areas." THOD OF CORRECTION: DON), or designee, could colicies and procedures on ucate staff on ensuring tancing and housekeeping and the spread of the diseat dit to ensure compliance.  | th<br>ed<br>Ild<br>The |                         |   |                                 |                          |

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Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:                  |                |   | (X3) DATE SURVEY<br>COMPLETED |                      |
|--|--|---|----------------|---|-------------------------------|----------------------|
|  |  | 00614   | B. WING        |   |                               | C<br>1 <b>8/2020</b> |
|  |  | 00614   |                |   | 1 11/1                        | 10/2020              |
| NAME OF I  | PROVIDER OR SUPPLIER                   | STREET AD   | DRESS, CITY, S | STATE, ZIP CODE   |                               |                      |
| ΤΔΙ ΔΗΙ  | NURSING AND REHA                       | B CENTER 1717 UNI   | VERSITY DR     | IVE SOUTHEAST   |                               |                      |
| IALAIII  | NONOINO AND NENA                       | SAINT CL  | OUD, MN 5      | 6304  |                               |                      |
| (X4) ID  |  | TEMENT OF DEFICIENCIES                                    | ID             | PROVIDER'S PLAN OF CORRECT                                    |                               | (X5)                 |
| PREFIX<br>TAG  |  | / MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION) | PREFIX<br>TAG  | (EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO |                               | COMPLETE<br>DATE     |
| 1710   |  | ,   | 1710           | DEFICIENCY)   |                               |                      |
| 21375  | Continued From pa                      | ge 47   | 21375          |   |                               |                      |
|  | . •                                    |   |                |   |                               |                      |
|  | TIME PERIOD FOR CORRECTION: Twenty-one |   |                |   |                               |                      |
|  | (21) days.                             |   |                |   |                               |                      |
| 21020  | MANI Ct. Ctatuta 444                   | CEA Cubal 40 Deticate 9                                   | 21830          |   |                               | 40/00/00             |
| 21030  | Residents of HC Fa                     | .651 Subd. 10 Patients &                                  | 21030          |   |                               | 12/23/20             |
|  | Residents of the Fa                    | ac.biii of Rights   |                |   |                               |                      |
|  | Subd. 10. Particip                     | pation in planning treatment;                             |                |   |                               |                      |
|  | notification of family                 |   |                |   |                               |                      |
|  |  |   |                |   |                               |                      |
|  |  | Il have the right to participate                          |                |   |                               |                      |
|  |  | neir health care. This right                              |                |   |                               |                      |
|  |  | unity to discuss treatment and dividual caregivers, the   |                |   |                               |                      |
|  |  | est and participate in formal                             |                |   |                               |                      |
|  |  | and the right to include a                                |                |   |                               |                      |
|  |  | other chosen representative or                            |                |   |                               |                      |
|  |  | hat the resident cannot be                                |                |   |                               |                      |
|  |  | ember or other representative                             |                |   |                               |                      |
|  |  | lent may be included in such                              |                |   |                               |                      |
|  | conferences.                           | vho enters a facility is                                  |                |   |                               |                      |
|  |  | natose or is unable to                                    |                |   |                               |                      |
|  |  | acility shall make reasonable                             |                |   |                               |                      |
|  |  | under paragraph (c) to notify                             |                |   |                               |                      |
|  |  | nber or a person designated in                            |                |   |                               |                      |
|  |  | ent as the person to contact in                           |                |   |                               |                      |
|  |  | the resident has been                                     |                |   |                               |                      |
|  |  | lity. The facility shall allow the                        |                |   |                               |                      |
|  |  | articipate in treatment<br>e facility knows or has reason |                |   |                               |                      |
|  |  | ent has an effective advance                              |                |   |                               |                      |
|  |  | trary or knows the resident has                           |                |   |                               |                      |
|  |  | that they do not want a family                            |                |   |                               |                      |
|  |  | n treatment planning. After                               |                |   |                               |                      |
|  |  | ember but prior to allowing a                             |                |   |                               |                      |
|  |  | articipate in treatment                                   |                |   |                               |                      |
|  |  | y must make reasonable<br>vith reasonable medical         |                |   |                               |                      |
|  | T                                      | ne if the resident has                                    |                |   |                               |                      |
|  |  |   |                |   |                               |                      |

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Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTIPL<br>A. BUILDING:  | E CONSTRUCTION      |  | (X3) DATE SURVEY<br>COMPLETED |                          |  |
|--|---|---|---------------------|--|-------------------------------|--------------------------|--|
|  |   | 00614   | B. WING             |  |                               | C<br><b>18/2020</b>      |  |
| NAME OF  | PROVIDER OR SUPPLIER  | STREET A  | DDRESS, CITY, S     | STATE, ZIP CODE  |                               |                          |  |
| TALAHI   | NURSING AND REHA  | BCENTER   |                     | IVE SOUTHEAST  |                               |                          |  |
|  | I   | SAINT C   | LOUD, MN 56         |  |                               |                          |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | N SHOULD BE                   | (X5)<br>COMPLETE<br>DATE |  |
| 21830  | Continued From pa   | ge 48   | 21830               |  |                               |                          |  |
|  | executed an advance sident's health car this paragraph, "rea (1) examining the resident; (2) examining the resident in the poss (3) inquiring of an family member con whether the resider directive and wheth physician to whom care; and (4) inquiring of the resident normally gwhether the resider directive. If a facilit designated emerge member to participa accordance with this liable to resident for the notification of the mergency contact family member was patient's privacy rig (c) In making rea family member or defacility shall attemembers or a design examining the person and the medical reconsession of the facility a family member or defacility a family member or defacility a family member or design and the medical reconsession of the facil social service agen agency that the resident facility has been appeared to the facility has been accordance with the resident facility has been agency that the resident facility has been accordance. | ce directive relative to the e decisions. For purposes of asonable efforts" include: e personal effects of the ession of the facility; by emergency contact or tacted under this section at has executed an advance er the resident has a the resident normally goes for e physician to whom the pes for care, if known, at has executed an advance by notifies a family member or ncy contact or allows a family ate in treatment planning in so paragraph, the facility is not a damages on the grounds that is family member or or the participation of the improper or violated the | t                   |  |                               |                          |  |

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING: |  |       | (X3) DATE SURVEY<br>COMPLETED |  |
|--|---|--|---|--|-------|-------------------------------|--|
|  |   |  | 7. BOILDING                             |  |       |                               |  |
|  |   | 00614  | B. WING                                 |  |       | 8/2020                        |  |
| NAME OF  | PROVIDER OR SUPPLIER  | STREET AD  | DRESS, CITY,                            | STATE, ZIP CODE  |       |                               |  |
| TALAHI   | NURSING AND REHA  | AB CENTER  | VERSITY DR<br>LOUD, MN 5                | NVE SOUTHEAST<br>6304  |       |                               |  |
| (X4) ID<br>PREFIX<br>TAG                         | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE | (X5)<br>COMPLETE<br>DATE      |  |
| 21830  | county social service enforcement agency identifying and notification designated emerges service agency or lethat assists a facility subdivision is not list damages on the grather family member participation of the or violated the patient of the | ce agency and local law cy shall assist the facility in fying a family member or ency contact. A county social ocal law enforcement agency y in implementing this able to the resident for ounds that the notification of or emergency contact or the family member was improper ent's privacy rights.  ent is not met as evidenced  and document review, the ure the appointed guardian nely manner of refused 1 residents (R2) reviewed who boratory monitoring and ed multiple doses of | 21830                                   | Corrected  |       |                               |  |

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| STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |   | , ,                       | LE CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                          |
|---|---|--|---|---------------------------|---|-------------------------------|--------------------------|
|   |   |  |   | A. BOILDING.              | · <del></del>   |                               |                          |
|   |   | 00614  |   | B. WING                   |   |                               | 8/2020                   |
| NAME OF I   | PROVIDER OR SUPPLIER  |  | STREET AD   | DRESS, CITY, S            | STATE, ZIP CODE   |                               |                          |
| TALAHI  | NURSING AND REHA  | B CENTER   |   | VERSITY DR<br>LOUD, MN 50 | IVE SOUTHEAST<br>6304   |                               |                          |
| (X4) ID<br>PREFIX<br>TAG                              | SUMMARY STA<br>(EACH DEFICIENC)<br>REGULATORY OR L  |  | EDED BY FULL  | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE                         | (X5)<br>COMPLETE<br>DATE |
| 21830   | Continued From pa   | ige 50   |   | 21830                     |   |                               |                          |
|   | appointed guardian party.   | ı (G)-A as his ı   | responsible   |                           |   |                               |                          |
|   | On 11/13/20, at 12: G-A explained she which had happened assaulting another nursing home, and mental state had be meds." G-A voiced weeks afterwards, refused the laborate subsequently had rantipsychotic medicat the lack of timely the facility had held towards the end of "not one word" of the was mentioned.   | was aware of ed involving R2 resident while expressed frueen "stable un she had not bon 11/2/20, thory monitoring not been provication. G-A vor notification at a care confer October, and he refusal and  | an incident 2 sexually 2 residing at the 2 sexually 3 residing at the 2 stration as R2's 3 rill he went off his 3 seen notified until 3 lat R2 had 4 and 5 ded his ordered 5 siced frustration 6 lat expressed 7 rence with her 8 still even then 8 held medication |                           |   |                               |                          |
|   | R2's progress note pharmacy came to medication and dra refused and threw I The note outlined, '[sic] medication sin The note identified updated.  | deliver R2's a<br>lw routine labo<br>his coffee at th<br>"Pharmacy un<br>ice resident re   | antipsychotic<br>pratory work. R2<br>he employee.<br>nable to delivery<br>efused lab draw."   |                           |   |                               |                          |
|   | R2's Medication Addated 10/2020 to 10 physician ordered resubsequent adminitives listed for clozal medication) 500 miles had a listed start date was record as being until 10/20/20. From MAR identified neal medication were not start of the | 1/2020, identifications an stration recording the control of the c | fied R2's nd their d(s). An order esychotic everyday; which . The medication onsumed by R2 11/5/20, the uent doses of the   |                           |   |                               |                          |

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|                          |   |  | PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                       | E CONSTRUCTION  |        | (X3) DATE SURVEY<br>COMPLETED |  |  |
|--------------------------|---|--|--|-----------------------|---|--------|-------------------------------|--|--|
| 7112121                  | TO TOTAL CONTON   |  | OTT TOMBET   | A. BUILDING:          |   |        |                               |  |  |
|                          |   | 00614  |  | B. WING               |   | 11/1   | 8/ <b>2020</b>                |  |  |
| NAME OF                  | PROVIDER OR SUPPLIER  |  | STREET AD  | DRESS, CITY, S        | STATE, ZIP CODE   |        |                               |  |  |
|                          |   |  | /ERSITY DR<br>.OUD, MN 50  | IVE SOUTHEAST<br>6304 |   |        |                               |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICI<br>Y MUST BE PRECED<br>SC IDENTIFYING INI  | ED BY FULL   | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | ULD BE | (X5)<br>COMPLETE<br>DATE      |  |  |
| 21830                    | Continued From particles of, "18," which was not available from particles of the particles | identified via leach armacy."  Plan Conference entified a quarter en held with G-And licensed social labeled, "Psychological which outlined en reviewed an ile. The complete R2's refused leach and lacked en had been immeratory monitoring cation being held to be a held because the permedication with the cause of and the later of the cause of all of this [the calized on 11/3/2] alized on 11/3/2 | ce Summary, rly care A in attendance al worker hotropic Med R2's and informed ted form laboratory olding of his was discussed orded progress evidence R2's ediately notified g and his d as a result.  Ind LSW-A were refused his his clozapine of the cart was updated on onference was aboratory draw ssed as she use events]" | 21830                 |   |        |                               |  |  |

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| STATEME                          | NT OF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |                          | E CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |                          |
|----------------------------------|---|---|--------------------------|---|-------------------------------|--------------------------|
|                                  |   |   |                          | <del> </del>  | C                             |                          |
|                                  |   | 00614   | B. WING                  |   | 11/1                          | 8/2020                   |
| NAME OF                          | PROVIDER OR SUPPLIER  | STREET ADI  | DRESS, CITY, S           | STATE, ZIP CODE   |                               |                          |
| TAI AHI NURSING AND REHAB CENTER |   |   | /ERSITY DR<br>OUD, MN 50 | IVE SOUTHEAST<br>5304   |                               |                          |
| (X4) ID<br>PREFIX<br>TAG         | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>'MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | D BE                          | (X5)<br>COMPLETE<br>DATE |
| 21830                            | •   |   | 21830                    |   |                               |                          |
|                                  | director of nursing (of the exact date will formally notified of the and subsequent and held; however, recand 10/26/20 at some to the DON voiced held been for R2's guard day the laboratory of | in Condition policy, dated a purpose of ensuring prompt ges in the resident's physical, remental status to the sponsible party. The policy amples of issue(s) which tification' including, "A need to medical treatment Refusal of treatment or to (2) or more consecutive THOD OF CORRECTION: The DON, or designee, could colicies and procedures and mely notification to resident d/or guardians; then audit |                          |   |                               |                          |

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