

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered August 17, 2021

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

RE: CCN: 245438 Cycle Start Date: June 17, 2021

Dear Administrator:

On July 23, 2021, we notified you a remedy was imposed. On August 6, 2021 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of August 3, 2021.

As authorized by CMS the remedy of:

• Mandatory denial of payment for new Medicare and Medicaid admissions effective September 17, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of July 1, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 17, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on August 3, 2021, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 23, 2021

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

RE: CCN: 245438 Cycle Start Date: June 17, 2021

Dear Administrator:

On July 1, 2021, we informed you that we may impose enforcement remedies.

On July 1, 2021, the Minnesota Department(s) of Health and Public Safety completed a revisit/survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

### 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(ies) 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:

• Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 17, 2021

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 17, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 17, 2021.

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. This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

• Civil money penalty. (42 CFR 488.430 through 488.444)

## NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by September 17, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Talahi Nursing And Rehab Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 17, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

## ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable 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), 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 - 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 December 17, 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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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

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 <u>Tamika.Brown@cms.hhs.gov.</u>

# 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: <u>https://mdhprovidercontent.web.health.state.mn.us/ltc\_idr.cfm</u>

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:

https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html

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,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			1		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	<u>MB NO.</u>	0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				СОМ	E SURVEY IPLETED
		245438	B. WING				C 01/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		0.1/2021
	NURSING AND REHA	B CENTER			717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	rs	FO	000			
	conducted at your f to be not in complia	1, an abbreviated survey was acility. Your facility was found ance with the requirements of art B, Requirements for Long s.					
	SUBSTANTIATED:	074219), with deficiencies					
	as your allegation of Departments accept enrolled in ePOC, y at the bottom of the	f correction (POC) will serve of compliance upon the otance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will tion of compliance.					
F 686 SS=D	onsite revisit of you validate that substa regulations has bee Treatment/Svcs to	Prevent/Heal Pressure Ulcer	F 6	86			8/3/21
	resident, the facility (i) A resident receiv professional standa pressure ulcers and ulcers unless the in demonstrates that t (ii) A resident with p necessary treatmen	sure ulcers. prehensive assessment of a must ensure that- es care, consistent with ards of practice, to prevent d does not develop pressure dividual's clinical condition they were unavoidable; and pressure ulcers receives ht and services, consistent					
	ically Signed	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE 07/28/2021
	ically olyneu						01/20/2021

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.

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TIE	PLE CONSTRUCTION		SURVEY	
	F CORRECTION	IDENTIFICATION NUMBER:				PLETED	
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		245438	B. WING		07/0	01/2021	
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	CODE		
TALAHI N	IURSING AND REHA	B CENTER		1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304			
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F 686	Continued From pa	ige 1 andards of practice, to	F 686	3			
	promote healing, promot	revent infection and prevent					
	Based on interview facility failed to com develop care plan i assessed to be at r subsequently devel	v and document review, the pprehensively assess and nterventions for a resident isk for pressure ulcers, who lopment of a stage 2 pressure ess skin loss with exposed		How corrective action will be accomplished for those residents have been affected by the deficie practice: R1 discharged from our facility			
	ulcer (partial-thickness skin loss with exposed dermis), for 1 of 3 residents (R1) reviewed for pressure ulcers. In addition, the facility failed to update the medical provider after a pressure ulcer was initially observed and failed to ensure appropriate interventions were communicated to all necessary caregivers following the development of the stage 2 pressure ulcer to prevent potential for worsening of the ulcer.			How the facility will identify other having the potential to be affected same deficient practice: Residents in our building who are via the Braden Assessment have potential to be affected by the sat deficiency. Residents who have a identifying at risk have had their of plans reviewed for further interve	d by the e at risk the me a Braden care		
	Findings include:			Weekly Skin Checks have been i for new skin alterations.			
	5/21/21, identified F 5/14/21 related to a infection of the skin cognition with diagr medication noncom obesity, renal impa conditions. The MD extensive physical living (ADL) and ex incontinence of bot R1 was at risk for p No alterations to R	himum Data Set (MDS), dated R1 had been admitted on cellulitis (a serious bacterial h). R1 had moderately impaired hosis of intellectual disability, hpliance, diabetes (DM), irments and multiple cardiac DS identified R1 required assist with activities of daily perienced frequent h bowel and bladder. Further, pressure ulcer development. 1's skin were reported at that had treatments as follows:		What measures will be put into p systemic changes made, to ensu deficient practice will not recur: The baseline care plan will be co to its entirety and will be reviewed Braden scores will be reviewed u completion by the IDT team and intervention will be implemented needed. Education is provided to nurses surround identification of at increased risk for developing p injuries, prompt documentation o wounds, provider notification and	re the mpleted d by IDT. pon as licensed residents pressure f new		

Facility ID: 00614

If continuation sheet Page 2 of 19

		& MEDICAID SERVICES					0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		PLETED	
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NAME OF F	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	_		
TALAHI I	NURSING AND REHA	B CENTER			717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETIO DATE	
F 686	Continued From pa	ige 2	F 6	86				
	antibiotic and diuretic medication, along with the use of oxygen. R1's admission MDS Care Area Assessments				How that facility will monitor its corractions to ensure that the deficient practice is being corrected and will recur:	deficient		
	<ul> <li>Nutritional Status, "Potential for altera to elevated BMI [bo receive a therapeut "Other diseases an nutritional needs" h "Pressure ulcers/inj unchecked with dire diagnosis list. See n overall objective for "Maintain current le would continue to b on.</li> <li>Pressure Ulcer/Inj "Actual" problem re ulcer/injury. Risk fa "Pressure" in which mattress or seat cu pressure," along wi altered mental statu renal and heart dise admitted, and using</li> </ul>	ne following information: dated 5/24/21: R1 had tion in nutritional status related ody mass index] and orders to tic diet." The section labeled d condition that can affect ad an available option for juries;" however, this remained ections to "See active nursing pain assessment." The r care planning was to evel of functioning" and R1 be monitored and care planned jury, dated 5/26/21: R1 had an elated to an existing pressure ctors were identified; n R1 needed a "special ishion to reduce or relieve th, immobility, incontinence, us, cognitive loss, diabetes, ease, pain, having been newly g devices that could cause oxygen. The CAA's impact of			The facility will audit weekly wound and at-risk residents with a Braden at risk and to validate that new wou are identified timeline, providers up and care plan/Kardex are updated. audits will be completed weekly x 2 months. Completed audits will be b to QAPI for review to determine if a changes are needed, to extend the the audits, or to discontinue. The date that each deficiency was corrected:8/3/2021 An electronic acknowledgement sig and date by an official facility representative Responsible Party: Director of Nurs Designee	score nd(s) dated, These rought ny time of		
	this problem/need of care planning to "m "CAA triggered rela risk for skin break of incontinence, decre areas to lower extre on admission. Trea lower extremities an with AM/HS [mornin bath. Staff assist hi	on R1 and the rationale for inimize risks" recorded the ted to resident [R1] being at down related to urinary eased mobility, DM, open emities and buttocks present tment in place and areas on re healing. Skin is observed ng and evening] cares and with m with repositioning in bed he all adjustments independently						

If continuation sheet Page 3 of 19

		AND HUMAN SERVICES				FORM	APPROVED
CENTER	S FOR MEDICARE	& MEDICAID SERVICES			10		0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			COM	E SURVEY PLETED
		245438	B. WING				C 01/2021
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
	NURSING AND REHA	B CFNTER			1717 UNIVERSITY DRIVE SOUTHEAST		
				5	SAINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	Continued From pa from side to side. S [medication and treat and progress notes Referral to Other Di any referral informa - Urinary Incontinent dated 5/26/21: R1 h to needing assistant incontinence. He has improved urinary co with transfers for to cleansing tasks inde to buttocks area on applied. Staff are to prn [as needed]. Se and progress notes R1's MARs, May ar following orders: - 5/14/21: "Diet orde hydration program a delegated to Regist order lacked any sp dietitian. - 5/26/21: "Ensure r turned/repositioned. Document refusals evidence of a turnin order prior to 5/26/2 R1's TARs, May and following order: - 5/26/21: "TO COC foam dressing daily wound cleanser even	inge 3 Bee assessments, MAR/TAR atment administration records] 5. Will care plan." The CAA's isciplines remained blank of ation. The cand Indwelling Catheter, had this "CAA triggered related the with toileting and as been using his urinal with portinence, he needs assist ileting not able to complete ependently. Open area noted admission, barrier creams offer toileting with rounds and be POC [point of care] charting 5. Will care plan." and June 2021, identified the ers, including supplements, and enteral nutrition may be tered (Certified) Dietitian." The becific changes per the resident is /off-loaded every 2 hours. every shift." The MARs lacked ng/repositioning/off-loading	1	586			
		nary, dated 5/14/21, identified					

Facility ID: 00614

If continuation sheet Page 4 of 19

PRINTED: 07/30/2021

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE					FORM	07/30/2021 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
	245438	B. WING				C 01/2021
NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
TALAHI NURSING AND REHA	B CENTER			717 UNIVERSITY DRIVE SOUTHEAST GAINT CLOUD, MN 56304		
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PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
extremity cellulitis. related to pressure Pre-Placement Rep compiled information identified a wound m 5/10/21 that reported extremity vascular of (area extending from to below the knee) at the report lacked even skin alteration(s), i.4 during his stay and/ R1's Admission Scr 5/14/21, identified at been completed on director of nursing ( two skin alterations leg and one on his admission screener been admitted with pressure ulcer(s) at comprehensive skin R1's Skin & Wound the following inform - Effective date 5/14 with an abrasion to (associated with im legs in a person with diabetic ulcer to his ulcer to his right shi section labeled "Ad the following interver "Moisture Control," supplementation." To presented additional	gnosis included right lower The summary lacked details ulcer(s). R1's Discharge bort was reviewed which on from his hospital stay and nurse progress note dated ed R1 had bilateral lower ulcerations within the gaiter m just above the ankle region area of both legs; however, vidence R1 had any additional e. pressure ulcer(s), noted /or upon discharge. reener - V3, effective date a Skin Observation section had 5/17/21 by the assistant (ADON) that indicated R1 had ; one on his right lower front left lower front leg. The r lacked evidence R1 had any other skin alterations i.e. nd lacked evidence of a n assessment section. I Evaluation V5.0s identified his left foot, a diabetic ulcer paired circulation of the lower th diabetes) to his left calf, a e left shin, and another diabetic in. Each evaluation had a ditional Care" which identified entions: "Moisture barrier,"	F6	586			

If continuation sheet Page 5 of 19

						). 0938-039			
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	· · /	TE SURVEY MPLETED			
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NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C					
TALAHI N	URSING AND REHA	B CENTER		1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE			
F 686	Continued From pa	-	F 68	36					
		adle, customized shoe wear, otection device, mobility aid(s),							
		g program, and "other" which cked. In addition, the							
		ed a "Notifications" section that							
		e party, dietician, and therapy							
	- Effective date 5/2	6/21 (12 days later): R1							
		previously identified skin er, R1 had documentation this							
		ge 2 (partial thickness skin							
	loss with exposed of	dermis (second layer of skin)"							
		base of the spinal column) e evaluation identified the							
	•	been present on admission							
	and had an "Exact	Date" of 5/14/21. The pressure							
		centimeters (cm) long by 4.8							
		nd bed had 20 percent (%)							
		er of skin) coverage, along slough (dead tissue). The							
		ection indicated the following							
		sture barrier," "Moisture							
	Control," and "Cusl	hion." No other additional care							
		d and the "Notification" section							
	remained unchecke	ed. /21: R1's "Stage 2" coccyx							
		asured 4.9 cm long by 4.1 cm							
		ed had 100% slough with a							
	"moderate" amoun	t of "serous (thin, watery and							
		th no odor. The pressure ulcer							
		The "Additional Care" section dimensional moisture barrier and control,							
		dietary supplementation, in							
		repositioning program"							
	intervention had be	en checked. The "Notification"							
	section remained u								
	- Effective date 6/9/ pressure ulcer mea	/21: R1's "Stage 2" coccyx							

If continuation sheet Page 6 of 19

		AND HUMAN SERVICES				FORM	: 07/30/2021 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		LE CONSTRUCTION	(X3) DATI COM	E SURVEY IPLETED
		245438	B. WING	·			C 01/2021
NAME OF I	PROVIDER OR SUPPLIER		-	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
TALAHI	NURSING AND REHA	B CENTER			1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 686	wide. The wound be connective tissue) v indicated a "light" a with no odor. The p "stable." The "Addit continued moisture cushion. The evalua intervention of a tur program or nutrition "Notification" sectio - Effective date 6/17 pressure ulcer mea wide. The wound be granulation and 90% however, a "modera drainage was noted "stable." The "Addit continued moisture cushion only and th remained unchecke - On 6/23/21, R1 ha V5.0 completed for however, R1's med the "Stage 2" coccy evaluated that day. R1's Braden Scale Risk (Braden), effec R1 was slightly limit meaningfully to pre- an occasionally mo was exposed to mo physical activity, wa to change and cont adequate pattern of potential problem in shearing. The Brad	ed had 10% granulation (new with 90% slough and had mount of serous drainage ressure ulcer had been tional Care" section indicated barrier and control and a ation no longer indicated the ming and repositioning h/dietary supplementation. The in remained unchecked. 7/21: R1's "Stage 2" coccyx isured 3.1 cm long by 2.5 cm ed continued to have 10% % slough with no odor; ate" amount of serous d. The pressure ulcer had been tional Care" section indicated barrier and control and a ne "Notification" section ed. ad Skin & Wound Evaluations his lower leg skin alterations; ical record lacked evidence for Predicting Pressure Sore ctive date 5/14/21, identified ted in his ability to respond ssure-related discomfort, had ist degree to which his skin pisture, walked occasionally for as slightly limited in his ability rol his body position, had an f food intake, and had a n relation to friction and en indicated a score of 17 R1 at a "Mild Risk" for	F	586			

If continuation sheet Page 7 of 19

		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES	<del>.                                    </del>			DMB NO. 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	Сом	E SURVEY PLETED
		245438	B. WING				C 01/2021
NAME OF F	PROVIDER OR SUPPLIER			ç	STREET ADDRESS, CITY, STATE, ZIP CODE		
					1717 UNIVERSITY DRIVE SOUTHEAST		
	NURSING AND REHA	BCENTER		\$	SAINT CLOUD, MN 56304		
	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO		(X5)
(X4) ID PREFIX		/ MUST BE PRECEDED BY FULL	PREFIX	х	(EACH CORRECTIVE ACTION SHOULD		COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROP		DATE
					DEFICIENCY)		
F 686	Continued From pa	nae 7	F 6	-		_	
	Oonandou i rom pa	ger	1.0	00			
	Subsequent Brader	n assessments were					
		n 5/21/21, 5/28/21, 6/4/21, and					
		den assessment indicated					
		4 which categorized R1 at a					
		pressure ulcer development.					
		lacked evidence of any					
	initiated and/or adju						
		ponse to R1's increased					
		based on these completed					
	Braden assessmen	•					
	R1's Baseline Care	Plan/Evaluation - V8,					
		kmarks that identified he had					
		ncontinence, was diabetic,					
		kin integrity issues." The					
		ecify skin integrity issues"					
		e section labeled "Skin					
		are" identified a checked					
		lteration in skin integrity					
		itional checkmarks for "Goal: I					
		lications and minimized pain					
		alteration through the review					
	date" with "Interven						
		eredKeep my skin well					
		ionMinimize edema of my					
		e my legs." A section labeled					
		down" remained without					
	checkmarks. The s						
		Status" indicated R1 had a					
		istent carbs, regular textures,					
		a dietary goal to maintain his					
		dietary section indicated he					
		ntially altered nutritional status					
		osis of diabetes. The dietary					
		tify concerns related to skin					
		ition/dietary supplementation.					
		le care plan lacked evidence					
		grity issues or specific					
	or specific skin inter	ging issues of specific					

If continuation sheet Page 8 of 19

						FORM	APPROVED		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				гірі			0938-0391 E SURVEY		
			l` í		B		PLETED		
					·		С		
		245438	B. WING				01/2021		
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE				
				1	1717 UNIVERSITY DRIVE SOUTHEAST				
		BOENTER		S	INT CLOUD, MN 56304				
			ID	_	PROVIDER'S PLAN OF CORRECTIO		(X5)		
			PREFIX TAG	K	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETION DATE		
					DEFICIENCY)				
F 686	-	-	F 6	86	j l				
	000,								
		·y.							
		Check - V3's identified the							
	following informatio								
	<ul> <li>Effective date 5/20 skin alteration(s).</li> </ul>	0/21: lacked evidence R1 had							
		7/21: lacked evidence R1 had							
	skin alterations(s).								
		21: R1 had a pressure ulcer							
		hree vascular ulcers; right							
		front lower leg, right rear lower							
		a lacked the pressure ulcer							
		d R1 had "No" new skin							
	alterations identified								
		21: lacked evidence R1 had							
		owever, indicated R1 had +3							
	pitting edema to bil								
		0/21: R1 had a pressure ulcer hree vascular ulcers. The skin							
	5	nce of the pressure ulcer							
		bservations. In addition, the							
		d R1 had "No" new skin							
	alterations identified								
		7/21: R1 had a pressure ulcer							
	2	hree vascular ulcers. The skin ressure ulcer measurements							
		addition, the skin check							
		No" new skin alterations							
	identified.								
	following informatio	e care plan identified the							
		: "The resident has Diabetes							
		entions to check body for skin							
		t promptly as ordered by							

If continuation sheet Page 9 of 19

STATEMENT OF DEFICIENCIES AND FLAN OF CORRECTION       (M1) PROVIDERGUPLIENCIAL DEPTIFICATION NUMBER:       (D2) MULTIFIE CONSTRUCTION A BUILDING       (M2) PATE BUINEY COMPLETED B WING       (M2) PATE BUINES (M2) PATE BUINEY (M2) PATE BUINEY (M		-	AND HUMAN SERVICES				FORM	APPROVED 0938-0391
Z45438     B. WING     C       NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE     1772 UNVERSITY DRIVE SOUTHEAST       TALAHI NURSING AND REHAB CENTER     STREET ADDRESS, CITY, STATE, ZIP CODE     1772 UNVERSITY DRIVE SOUTHEAST       Image: Continued From page 9     0     PROVIDER OF CONRECTION PROTORECTION OF DEFICIENCES       Image: Continued From page 9     0     PROVIDER TO THE APPROPRIATE DEFICIENCY)     000000000000000000000000000000000000	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			E CONSTRUCTION	(X3) DATE	E SURVEY
MAKE OF PROVIDER OR SUPPLIER       STREET ADDRESS. CTV: STRE. 2IP CODE         TALAHI NURSING AND REHAB CENTER       TATU UNIVERSITY DRIVE SOUTHEAST         (%1)D TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST EX ENCEDED BY PLLL REGULATORY OR LSC IDENTIFYING INFORMATION)       D PROVIDER'S ALL OCORRECTIVE ACTION SHOLD BE (EACH DEFICIENCY MUST EX ENCEDED BY PLLL REGULATORY OR LSC IDENTIFYING INFORMATION)       D PROVIDER'S ALL OCORRECTIVE ACTION SHOLD BE (EACH DEFICIENCY MUST EX ENCEDED BY PLLL REGULATORY OR LSC IDENTIFYING INFORMATION)       F 686         F 686       Continued From page 9 doctor and to monitor/document/report as needed any signs and symptoms of inflection to any open areas. - Revised on 6/9/21: "I have an alteration in skin integrity nft [related to] sacral ulcer, R [right] calf ulcer, and bilateral heel (R+L) diabetic ulcers? with a goal '1 will be free of complications and minimized pain related to my skin alteration through the review date." Interventions were identified which were initiated on 5/14/21 by the completion of the baseline care plan with adjustments made on 6/4/21 to levate his legs due to venous insufficiency, administer his treatments as ordered, and directed staff to apply "Blue Pressure relieving boots on outside of transferring." - Revised on 6/24/21: "The resident has potential for altered nutrition/diatary supplementation or specific dietary interventions to address R1's wounds. - The care plan lacked evidence R1 had a risk for pressure ulcer devidence R1 had a risk for pressure ulcer/skin alteration development and interventions to help decrease his risk footows.         R1's Kardex [nursing assistant plan of care], printed 6/30/21, directed staff to apply the blue pressure relieving boots outside of transferring R1. R1's Kardex [acked evidence that identiff			245438					
1712 UNIVERSITY OF US OUTHEAST SAINT CLOUD, MN 56304       (2M) D PREFIX TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG     D PREFIX     (CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG     COMMETTOR (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG       F 686     Continued From page 9 doctor and to monitor/document/report as needed areas. - Revised on 6/9/21: "I have an alteration in skin integrity r/ft pelated to Isacral ucer, R (right) caif uloer, and bilateral heel (R+L) diabetic ulcers" with a goal "I will be free of complications and minimized pain related to my skin alteration through the review date." Interventions were identified which were initiated on 5/4/21 by the completion of the baseline care plan with adjustments made on 6/4/21 to elevate his legs due to venous insufficiency, administer his treatments as ordered, and directed staff to apply "Blue Pressure relieving boots on outside of transferring." - Revised on fize/4/21: "The resident has potential for altered nutrition/distary styleplementation or specific dietary interventions to help decrease his risk for pressure ulcer/skin alteration development and interventions or help decrease his risk for pressure ulcer/skin alteration development and interventions to help decrease his risk for pressure ulcer/skin alteration directed staff to apply the blue pressure ulcer/skin alteration and interventions to help decrease associated risk factors.     R''s Kardex [nursing assistant plan of care], printed 6/30/21, directed staff to apply the blue pressure relieving boots outside of transferring RT. R1's Kardex lacked evidence that identified he had skin atterations and there taked     Interventions to help decrease his risk factors.	NAME OF F	ROVIDER OR SUPPLIER	·	<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE		<u></u>
SAINT CLOUD, MN 56304       (X4) ID PREFIX TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST EE REFECEDED & Y-LLL, REGULATORY OR LSC IDENTIFYING INFORMATION)     D PREFIX TAG     D PREFIX (EACH DEFICIENCY)     D PREFIX TAG     D PREFIX (EACH DEFICIENCY)     D PREFIX (EACH DEFICIENCY)     D (EACH DEFICIENCY)     C (ps) (EACH DEFICIENCY)       F 686     Continued From page 9 doctor and to monitor/document/report as needed any signs and symptoms of infection to any open areas. - Revised on 6/9/21: "I have an alteration in skin integrity nft [related to] sacral uder; R [right] calf ulcer, and bilateral heel (R+L) diabetic ulcers" with a goal 1 will be free of complications and minimized pain related to my skin alteration through the review date." Interventions were identified which were initiated on 5/14/21 to the completion of the baseline care plan with adjustments made on 6/24/21: The resident his legs due to venous insufficiency, administer his treatments as ordered, and directed staff to apply "Blue Pressure releving boots on outside of transferring." - Revised on 6/24/21: The resident has potential for altered nutritional status r/t DM, Obesity and wounds," which lacked vidence of nutrition/dietary supplementation or specific dietary interventions to help decrease his risk for pressure ulcer/skin alteration development and interventions to help decrease his risk for pressure ulcer development, other than the placement of blue pressure relieving boots. In addition, the care plan lacked evidence R1 had a risk for bowel and bladder incontinence and risk factors.     R1's Kardex [nursing assistant plan of care], printed 6/30/21, directed staff to apply the blue pressure relieving boots outside of transferring R1. R1's Kardex [acked evidence that Identified he had skin atterations and further lacked <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
Préčix TAG       (EACH OPERCENT MACTION)       PRÉTX TAG       (EACH OPERCENT & ACTION SHOULD BE CROSS-REFERENCE DI OT BE APPROPRIATE DEFICIENCY)       COMPLETION DATE         F 686       Continued From page 9 doctor and to monitor/document/report as needed any signs and symptoms of infection to any open areas. - Revised on 6/9/21: "I have an alteration in skin integrity n/t freidated to jascral ulcer, R [right] calf ulcer, and bilateral heel (R+L) diabetic ulcers" with a goal "I will be free of complications and minimized pain related to my skin alteration through the review date." Interventions were identified which were initiated on 5/14/21 by the completion of the baseline care plan with adjustments made on 6/4/21 to elevate his legs due to venous insufficiency, administer his treatments as ordered, and directed staft to apply "Blue Pressure relieving boots on outside of transferring." - Revised on 6/24/21: "The resident has potential for altered nutritional status r/t DM, Obesity and wounds," which lacked evidence of nutrition/dietary supplementation or specific dietary interventions to help decrease his risk for pressure ulcer development, other than the placement of blue pressure relieving boots. In addition, the care plan lacked evidence R1 had a risk for bowel and blader incontinence and interventions to help decrease his risk for pressure ulcer development, other than the placement of blue pressure relieving boots. In addition, the care plan lacked evidence R1 had a risk for bowel and blader incontinence and interventions to help decrease his risk for pressure ulcer development, other than the placement of blue pressure relieving boots. In addition, the care plan lacked evidence R1 had a risk for bowel and blader incontinence and interventions to help decrease associated risk factors.       R1 'S Kardex [nursing assistant plan of care], printed 6/30/21, directed staft to apply the blue pressu		IURSING AND REHAI	B CENTER					
doctor and to monitor/document/report as needed any signs and symptoms of infection to any open areas. - Revised on 6/9/21: "I have an alteration in skin integrity rft [related to] sacral ulcer, R [right] calf ulcer, and bilateral heel (R-L) diabetic ulcers" with a goal "I will be free of complications and minimized pain related to my skin alteration through the review date." Interventions were identified which were initiated on 5/14/21 by the completion of the baseline care plan with adjustments made on 6/4/21 to elevate his legs due to venous insufficiency, administer his treatments as ordered, and directed staft to apply "Blue Pressure relieving boots on outside of transferring." - Revised on 6//24/21: "The resident has potential for altered nutritional status r/t DM, Obesity and wounds," which lacked evidence of nutrition/dietary supplementation or specific dietary interventions to address R1's wounds. - The care plan lacked further evidence R1 had a risk for pressure ulcer/skin alteration development and interventions to help decrease his risk for pressure lote devidence R1 had a risk for bowel and bladder incontinence and interventions to help decrease associated risk factors. R1's Kardex [nursing assistant plan of care], printed 6/30/21, directed staff to apply the blue pressure relieving boots outside of transferring R1. R1's Kardex lacked evidence that identified he had skin alterations and further lacked	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	<	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE	COMPLETION
nutrition supplementation, pressure relieving bed and/or wheelchair cushion, toileting plan,	F 686	doctor and to monit any signs and symp areas. - Revised on 6/9/21 integrity r/t [related integrity integrity integrity integrity integrity integrity integrity interventions in the placement boots. In addition, the placement boots. In addition, the ressure relievent boots interventions to risk factors. R1's Kardex [nursin printed 6/30/21, dire pressure relieving brits for skin alteration interventions for skin alteration interv	<ul> <li>bor/document/report as needed borns of infection to any open</li> <li>: "I have an alteration in skin to] sacral ulcer, R [right] calf heel (R+L) diabetic ulcers" a free of complications and ted to my skin alteration date." Interventions were re initiated on 5/14/21 by the aseline care plan with on 6/4/21 to elevate his legs fficiency, administer his red, and directed staff to apply eving boots on outside of</li> <li>21: "The resident has potential al status r/t DM, Obesity and ked evidence of oplementation or specific s to address R1's wounds. Ked further evidence R1 had a cer/skin alteration her ventions to help decrease a ulcer development, other of blue pressure relieving he care plan lacked evidence of one plan lacked evidence of one plan lacked evidence of one plan lacked evidence of a ulcer development, other of blue pressure relieving he care plan lacked evidence of one plan lacked evidence on help decrease associated</li> </ul>	F 68	86			

If continuation sheet Page 10 of 19

	-	AND HUMAN SERVICES				FORM	07/30/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´			(X3) DATE COM	E SURVEY PLETED
		245438	B. WING				C 01/2021
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
TALAHI	NURSING AND REHA	B CENTER			717 UNIVERSITY DRIVE SOUTHEAST AINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 686	incontinence care, o program. R1's progress notes identified the follow - 5/18/21, at 8:17 a. R1 had vascular wo extremities in which adequate to suppor dietary recommend - 5/30/21, at 9:24 a. Orders-Administrat director of nursing ( is 100% slough, no small amount of se edges are red." - 6/10/21, at 2:38 p. Administration Note practical nurse (LPI care, passed onto F - 6/23/21, at 10:00 p emergency room at admitted for seizure unresponsiveness. Review of R1's pro- additional entries re ulcer. Review of R1's mee support a "stage 2" been present upon pressure ulcer indic the medical record medical provider(s) pressure ulcer after lacked that R1 had assessment perform related to R1's press	or a turning/repositioning s, dated 5/14/21 - 6/26/21 ing entries: .m. a dietitian entry identified ounds to bilateral lower n his "current intake is rt healing" and that no new lations were given at that time. .m. identified an ion Note entered by the (DON); "Bed of coccyx wound pain during dressing change, rous drainage with no odor, .m. identified an Orders- e entered by a licensed N); "missed wound [coccyx] PM's." p.m. R1 was sent to the t the St. Cloud Hospital and	F 6	86			

If continuation sheet Page 11 of 19

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/30/2021 APPROVED 0938-0391
STATEMENT OF DEL AND PLAN OF CORF	FICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```			(X3) DATE COM	E SURVEY PLETED
		245438	B. WING				C 01/2021
NAME OF PROVID	ER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
TALAHI NURSI		RCENTER		1	717 UNIVERSITY DRIVE SOUTHEAST		
		BOENTER		S	SAINT CLOUD, MN 56304		
	EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
initial recor interv press the ri "stag Whe nursi been cocc Kard on ho awar for R help get o direc need NA-A whee mattr verba conc Durir p.m. recol admi not ro press had t since bette ment [press expla of be	d lacked evide vention(s) to su sure ulcer deve sk of concerns e 2" coccyx pr n interviewed of ng assistant (N aware that R1 yx. NA-A ackno ex for resident by to care for t e of any sort of 1; however, st support him wi ff of his bottom ted his toileting ed to assist him had been uns elchair and/or r ress. After NA- alized "It does n erning R1's pre- ng a telephone licensed practi- lected having b ted that he ha ecollect if he has sure ulcer on h hought the coo e he got here;" r; however, la ined R1 initiall d and he had a	I. Furthermore, the medical ence R1 had care planned upport a decreased risk for elopment or to help decrease related to the documented	F	586			

If continuation sheet Page 12 of 19

		E & MEDICAID SERVICES				<u>). 0938-039</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY
			A. BUILDI	ING		С
		245438	B. WING		0-	
	PROVIDER OR SUPPLIER	2-0-00		STREET ADDRESS, CITY, STATE, Z		7/01/2021
	NOVIDER OR OOT LIER			1717 UNIVERSITY DRIVE SOUT		
TALAHI	NURSING AND REHA	AB CENTER		SAINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
E 696						
F 686	• · · · · · · · · · · · · · · · · · · ·	-	F 6	86		
		issue tolerance testing was not				
		lents to help determine turning programs and further stated,				
		ery two hours." LPN-B				
		lent had a change in condition				
		der would be updated by				
	whoever found the	change.				
	When interviewed	by tolophone on 6/20/21 of				
		by telephone on 6/30/21, at m wound care nurse LPN-A				
		that R1 had been admitted				
		er as she had not been in her				
	interim role at the t	ime of his admission; however,				
		had been "under the				
		ad been aware that R1 had a				
		admission when staff k of a pressure ulcer picture in				
		d. LPN-A had been unsure of				
		ght this to her attention. LPN-A				
		dent was admitted they would				
		oe skin assessment by a				
		RN). If a pressure ulcer was				
		were expected to ensure the				
		ed treatment, was documented screener assessment" and in				
		, an accompanying picture was				
		e pressure ulcer would have				
		ation every week" following it's				
		explained the comprehensive				
		as located in the admission				
		ent and the facility did not have				
		hensive skin assessment				
		oned on the facility's tissue tion process, LPN-A denied				
		this type of determination.				
		on how a resident had a turning				
	and repositioning p	program identified, LPN-A				
	stated that if a resi	dent were at risk "in my				
	practice it is evenu	two hours" and if "any [skin]				

If continuation sheet Page 13 of 19

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	07/30/2021 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	<u>// u (L</u>	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DAT COM	E SURVEY IPLETED
		245438	B. WING	i			C 01/2021
NAME OF PROVIDER OR SUP	LIER	•	•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
TALAHI NURSING AND F	<b>EH</b>	B CENTER			1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304		
PREFIX (EACH DEFIC	CIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
initiate or adju based on the n she expected check by the of form would ide replied "I woul should have b checks if it have evaluations. S not expected t measurement abnormalities] R1's medical p regarding his of admission and in her interim n During intervie nurse RN-B st been noted in 5/21/21] when MDS on 5/27// wrote R1's pre- had stated to h present on adi information was the purpose of their [the resid care of the pel RN-B confirmed planning proce did not determ that was a cas she had been resident repos performed tiss	werf resid resid art n entify d ima een i d bee She e o ad s as wee orovic cocc l exp o ad s as wee orovic cocc l exp art o e at a s as s as s as s as s as s as s as	age 13 e observed then they "would loading or repositioning" ent's risk factors. LPN-A stated ents would have a weekly skin urses in which the skin check "any skin abnormalities" and agine" R1's pressure ulcer dentified on his weekly skin en present during the explained the cart nurses were d the skin abnormality "we measure [the kly." LPN-A denied knowledge der had been updated /x pressure ulcer since his lained again she had not been at the time of his admission.	F	586			

If continuation sheet Page 14 of 19

		AND HUMAN SERVICES				FORM	07/30/2021 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245438	B. WING				C 01/2021
NAME OF	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
TALAHI	NURSING AND REHA	B CENTER			717 UNIVERSITY DRIVE SOUTHEAST AINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	a.m. the ADON con admission an RN c assessment in whice abnormalities "right identification, to sup facility acquired, an weekly wound roun admission a resider help determine pres- interventions would calculated score, all risk factors and nee- the skin section in t assessment went "a factors." She denier resident tissue toler a resident's individu turning/repositioning intervention and shi at risk they would b repositioned "every sacral coccyx ulcer much as you can." alteration(s) observ checks should be n and that the skin ch weekly wound roun She stated it was "r R1's weekly skin ch on [R1's] skin." The pressure ulcer had admission; "That de The ADON stated F redness upon admi observed again dur weekly wound roun explained the press [the admission redr	firmed upon a resident's ompleted a head to toe skin ch they documented any t away," along with photo pport the abnormality was not ad then followed up weekly with ads. The ADON explained upon nt had a Braden completed to ssure ulcer risk in which I be based off of the Braden's long with individual resident eds. In addition, she explained the admission screener a little more in-depth with risk d the facility performed rance testing to help determine	F	586			

Facility ID: 00614

If continuation sheet Page 15 of 19

		AND HUMAN SERVICES				FORM	07/30/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATI COM	E SURVEY IPLETED
		245438	B. WING	i			C 01/2021
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
TALAHI	NURSING AND REHA	B CENTER			1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 686	to determine treatm "pretty stable.". T medical provider ha pressure ulcer in wi documentation in h conversation with th further verbalized R wheelchair upon ad with an air mattress repositioning plan w She also was "prett on nutrition/dietary" [upon admission] fo prevent any new ulk these interventions plan, along with a c identified his skin al ADON stated the in skin alteration risk f pressure ulcer shou pulled to the Kardey nursing assistants w interventions. The <i>A</i> know R1's risk factor alterations and inter how to care for him potential for a deter alterations and/or n development. During interview on contracted pool stat use the Kardex for explained the Kardey know" in order to ca confirmed she had hospitalization on 6 R1's Kardex, she co	hent despite it having been The ADON verbalized R1's ad been updated on his hich there should have been is medical record to support a ne "triage nurse" and she R1 was given a cushion in his limission and he was provided a and an every two hour when the ulcer "opened up." by sure" R1 had been started supplementation "right away" or his venous leg ulcers and to cers. The ADON confirmed should have been in R1's care are plan section which literation risk factors. The terventions related to R1's factors and his current uld be in his care plan so that it x as once in the Kardex the would then know the ADON explained if staff did not fors and/or current skin rventions they would not know and he then would have the ioration of his current skin	F	586			

If continuation sheet Page 16 of 19

		AND HUMAN SERVICES				FORM	07/30/2021 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
		245438	B. WING	i			C 01/2021
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
TALAHI	NURSING AND REHA	B CENTER			717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 686	the Kardex did not i repositioning plan, i cushion in his whee had a toileting plan bowel/bladder incor interventions for toi work with him, it [Ka have to reposition h R1 required a reposi interventions, the K information "otherw he deserves." When interviewed of stated staff would re how to care for a re staff [NAs] to follow they [residents] are Thus, LPN-C expla interventions needed for this to happen. If expected interventions comprehensive car would be accurate a "flow over" to the Ka R1's Kardex, she ca information which in "other than the blue R1's Kardex lacked decrease skin altern program. LPN-C vo for repositioning if e voiced there was "a not be followed." LF repositioning progra there [the Kardex]" plan itself at least."	indicate if R1 had a used interventions such as a elchair or air mattress, that he or if he had indication of intinence, or any other leting. NA-B stated, "If I had to ardex] does not say I would him." Further, NA-B stated if sitioning plan, or other Cardex should have that <i>v</i> ise he is not getting the care on 7/1/21, at 11:39 a.m. LPN-C efer to the Kardex to know esident and that she expected what was indicated on it "so getting the proper care." ined resident care ed to be present on the Kardex Further, she stated she ons to be on the re plan so that the Kardex as care planned interventions ardex. After LPN-C reviewed onfirmed the Kardex lacked indicated R1 had skin issues a boots." She further confirmed d interventions to help ation risk other than a walking biced, "Our general guideline every two hours," and further always a potential that it would PN-C stated R1's turning and am "probably should be on and, "It should be on the care	F	586			

If continuation sheet Page 17 of 19

	-	AND HUMAN SERVICES				FORM	APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPI	LE CONSTRUCTION	(X3) DATE	E SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	·		IPLETED
		245438	B. WING				C 01/2021
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
	NURSING AND REHA	B CENTER			1717 UNIVERSITY DRIVE SOUTHEAST		
					SAINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
	Continued From pa director of nursing ( part of the care plan "execute their dutie she expected the K such as repositionin applicable to the res- interventions. The D resident intervention Kardex there was a any current skin alter review of R1's Kard Kardex lacked evide skin integrity and/or interventions, other stated she expected assessment to indic on admission, along comprehensive care factors for skin alter alterations that were DON explained she comprehensive ass after a new pressur with the medical pro- to "prevent further in ensure appropriate A policy Change in directed that the res- notified promptly wh of a pressure ulcer, be documented in t care plan would be A policy Care Plan/o	sc IDENTIFYING INFORMATION) age 17 (DON) stated the Kardex was in and is what the NAs used to s" for resident care and thus fardex to contain interventions ing and toileting plans if sident and any skin alteration DON explained if such specific ins were not identified on the a "risk for pressure injury" and erations may decline. After lex, the DON confirmed R1's ence which instructed staff on r coccyx pressure ulcer than the blue boots. The DON d the admission screener cate all skin alterations noted g with the base line and e plans should address risk erations; not just the skin e present. In addition, the a also expected a new sessment to be completed re ulcer was acquired, along ovider to be updated, in order njury or concern" and to wound treatment. Condition, revised 12/19/18, sidents physician would be hen there had been an onset in which the notification would the medical record and the updated as necessary. Conference, revised 1/25/21,			CROSS-REFERENCED TO THE APPROP DEFICIENCY)		
	resident received ca herself and that the	e was to ensure that each are individualized to him or goals and approaches for icated to caregivers. The					

Facility ID: 00614

If continuation sheet Page 18 of 19

		AND HUMAN SERVICES				FORM	07/30/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	СОМ	E SURVEY PLETED C
		245438	B. WING	i			_ 01/2021
NAME OF F	PROVIDER OR SUPPLIER	L		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
TALAHI I	NURSING AND REHA	B CENTER			717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	policy identified the based on the reside medical history and	comprehensive care plan was ent's medical condition, l assessments, and that the revised as information about	F	586			

Facility ID: 00614



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered July 23, 2021

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

Re: State Nursing Home Licensing Orders Event ID: 2RH711

Dear Administrator:

The above facility was surveyed on June 30, 2021 through July 1, 2021 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 <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html</u>. 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 "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.

An equal opportunity employer.

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,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Minnesc	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00614	B. WING		07/0	) 1/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TALAHI	NURSING AND REHA	BCENTER	VERSITY DR OUD, MN 5	IVE SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this corre- pursuant to a surver found that the defice herein are not corre- not corrected shall with a schedule of f the Minnesota Depa Determination of wi corrected requires of requirements of the number and MN Ru When a rule contai comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	that may result from orders provided that the Department wit	hearing on any assessments n non-compliance with these it a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	conducted at your f Minnesota Departm facility was found n State Licensure. Pl plan of correction y and identify the dat	rS: , a complaint survey was acility by a surveyor from the nent of Health (MDH). Your ot in compliance with the MN ease indicate in your electronic ou have reviewed these orders e when they will be completed.				
	epartment of Health Y DIRECTOR'S OR PROVIE	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE

Electronically Signed

If continuation sheet 1 of 24

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(2) MULTIPLE CONSTRUCTION BUILDING:		E SURVEY PLETED
		00614	B. WING			C 01/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
	NURSING AND REHA	B CENTER	IVERSITY DRI LOUD, MN 56	VE SOUTHEAST 304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 000	Continued From pa	ge 1	2 000			
	The following complaint was found to be SUBSTANTIATED: H5438118C (MN00074219) with licensing orders issued at 0545 and 0900.					
	SUBSTANTIATED: H5438118C (MN00074219)					
	orders are delineated Department of Hea you electronically. is necessary for Sta enter the word "CO available for text. You electronic State lice heading completion be corrected prior to the Minnesota Dep- is enrolled in ePOC	ed on the attached Minnesota Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please RRECTED" in the box ou must then indicate in the ensure process, under the n date, the date your orders wil o electronically submitting to artment of Health. The facility and therefore a signature is bottom of the first page of				

2RH711

If continuation sheet 2 of 24

Minnesota Department of	Health			FORMA	PPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S COMPL	
	00614	B. WING		C <b>07/0</b> 7	1/2021
NAME OF PROVIDER OR SUPPLI	ER STREET AD	DRESS, CITY,	STATE, ZIP CODE		
TALAHI NURSING AND RE	IAB CENTER	VERSITY DR .OUD, MN 5	RIVE SOUTHEAST 6304		
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETE DATE
FOURTH COLU "PROVIDER'S P APPLIES TO FE THIS WILL APP 2 545 MN Rule 4658.0 Resident Assess Subp. 3. Freque	page 2 GARD THE HEADING OF THE MN WHICH STATES, LAN OF CORRECTION." THIS DERAL DEFICIENCIES ONLY. EAR ON EACH PAGE. 400 Subp. 3 A-C Comprehensive ment; Frequency ency. Comprehensive resident ist be conducted:	2 000			8/3/21
A. within 14 d B. within 14 d the resident's ph C. at least or This MN Require by: Based on intervi- failed to ensure a Set (MDS) and a Assessment (CA timely for 1 of 3 d assessment acc Findings include The Centers for (CMS) Long-Terr Assessment Inst dated 10/2019, ic primary purpose problems which individualized ca from MDS asses Skilled Nursing F System (SNF PF	lays after the date of admission; lays after a significant change in ysical or mental condition; and ace every 12 months. ement is not met as evidenced ew and record review, the facility a comprehensive Minimum Data ssociated Care Area A) processes were completed residents (R1) reviewed for uracy.		The director of nursing or designed develop a system to educate staff develop a monitoring system to en MDS processes are completed tim Education will be provided to the S representative on timely completion MDS/CAA on newly admitted resid Audits will be conducted twice mor Director of nursing or designee and information will be brought to QAP	and sure lely. S n of ents. nthly by d	

2RH711

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	0. 00		A. BUILDING:			
		00614	B. WING			C 01/2021
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	NURSING AND REHA	BCENTER	IVERSITY DRI	VE SOUTHEAST 304		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 545	Continued From pa	age 3	2 545			
	provided to nursing identified comprehe completion is defin process in addition that the RN [registe coordinator has sig (item Z0500) and C completion attestat instructed the MDS (comprehensive) c Z0500 and V0200E "14th calendar day (admission date +   manual provided at accurate coding for assessment as foll "Section C: Cogniti	ve Patterns," with intent "to	•			
	ability to register ar These items are cr care-planning decis					
	distress, a serious	' with intent to "address mood condition that is nd under-treated in the nursing	9			
	behavioral symptor the resident and/or members or the ca behaviors may place isolation, and inact	or," with intent to identify ms that may cause distress to other facility residents, staff are environment. "These ce the resident at risk for injury ivity and may also indicate ds, preferences, or illness."	<b>,</b>			
	had an admission of	DS dated 5/21/21, identified R1 date of 5/14/21, and had been reimbursement for his stay.				

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		IDENTIFICATION NOMBER.	A. BUILDING:			
		00614	B. WING		_ C _ 07/01/2021	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	NURSING AND REHA		IVERSITY DRI LOUD, MN 56	VE SOUTHEAST 304		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 545	Continued From pa	age 4	2 545			
	and medication nor diagnosis included in which R1 require with his activities of indicated R1 had m identified he report or hopeless," "feeli and "feeling bad at failure or have let y several days during The MDS "Section Administration" ind item Z0500, had be days late per RAI a instructions). The M Assessment (CAA)	nosis of intellectual disability ncompliance. Further cellulitis, diabetes, and obesity ed extensive physical assist f daily living (ADL's). The MDS ninimal depression; however, red "feeling down, depressed, ng tired or having little energy, bout yourself - or that you are a vourself or your family down" g the MDS assessment period. Z - Assessment icated sections "C ,D, E" and een completed on 6/1/21 (five admission completion MDS "Section V - Care Area ) Summary" indicated item completed on 6/1/21 (five days	•			
	nurse (RN)-B ackn MDS and CAA pro- timely per the RAL R1's admission ME have been complet of his stay [5/27/21 and CAA processe they drove care pla "take care of a pers can." Lateness of t potential for delayer resident's admission (ARD) would be set stay.	on 6/30/21, at 2:33 p.m. MDS owledged R1's admission cess had not been completed requirements. RN-B voiced DS and CAA processes should ted on or before the 14th day ]. RN-B explained the MDS s needed to be done timely as anning processes in order to son [resident] the best you his process also had "the ed treatment." RN-B identified a on assessment reference date stup for day eight of a resident's n 6/30/21, at 2:57 p.m. the	3			
	social services dire	ector (SSD) acknowledged she S sections C, D, and E, along				

2RH711

Minnesota Department of Health         STATEMENT OF DEFICIENCIES         AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:         00614		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		IDENTITION TON NOMBER.	A. BUILDING:			
		B. WING		C 07/01/2021		
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	NURSING AND REHA	ABCENTER		VE SOUTHEAST		
(X4) ID	SUMMARY ST		LOUD, MN 56	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	COMPLET DATE
2 545	Continued From pa	age 5	2 545			
	attempted to comp as she could which days after the ARD been aware of the MDS and CAA com she explained she [Point Click Care M when things are du had completed R1' required date. She completing the MD the residents needs purposes and fund processes had the and "not having ce order to "care for th voiced she "does the	CAAs. She stated she lete the MDS process as soon a typically was "five or seven "." The SSD voiced she had no RAI manual instructions for appletion timeframe's; however, "tends to look at the computer MDS software] system to see te." She denied knowledge she s MDS process past the explained the purpose of S process was to capture wha s were for care planning ing, and that late MDS potential for "payment issues" rtain pieces of the care plan" in the residents properly. The SSE he best" she can being she worker in the building.	t t			
	director of nursing the MDS and CAA "per the regulations and CAA lateness "something that is time" and voiced th	on 7/1/21, at 11:52 a.m. the (DON) stated she expected processes to be completed s." The DON explained MDS had the potential to miss going on in that window of he example that if a resident c "we could have falls."				
	indicated the interd expected to use the directed the "Admis	Process, revised 3/15/21, lisciplinary team (IDT) was e MDS 3.0 RAI manual and ssion assessments (MDS and pleted within fourteen (14)				
	The director of nurse review and revise p	THOD OF CORRECTION: sing (DON) or designee could policies and procedures related Set (MDS) process completion	1			

2RH711

	ta Department of He					
	STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
					С	
	00614		B. WING	07	/01/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY,	STATE, ZIP CODE		
	NURSING AND REHA	AB CENTER				
	SUMMARY ST		CLOUD, MN 5	PROVIDER'S PLAN OF CORRECTION	(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETE DATE	
2 545	Continued From page 6		2 545			
	designee could dev	he director of nursing or velop a system to educate sta nitoring system to ensure MD upleted timely.				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-or	le			
2 900	MN Rule 4658.052 Ulcers	5 Subp. 3 Rehab - Pressure	2 900		8/3/21	
	comprehensive res of nursing services	sores. Based on the sident assessment, the direct must coordinate the nursing care plan which	or			
	without pressure s pressure sores unle condition demonstr	to enters the nursing home ores does not develop ess the individual's clinical rates, and a physician they were unavoidable; and				
	receives necessar	who has pressure sores y treatment and services to revent infection, and preven veloping.	t			
	by: Based on interview facility failed to con develop care plan i assessed to be at r	ent is not met as evidenced and document review, the aprehensively assess and nterventions for a resident risk for pressure ulcers, who		How corrective action will be accomplished for those residents found to have been affected by the deficient practice:		
	ulcer (partial-thickn dermis), for 1 of 3 r	lopment of a stage 2 pressu ness skin loss with exposed residents (R1) reviewed for n addition, the facility failed to		R1 discharged from our facility How the facility will identify other residents having the potential to be affected by the	6	

2RH711

If continuation sheet 7 of 24

Minnesota Department of Health         STATEMENT OF DEFICIENCIES         AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:         00614		(X2) MULTIP A. BUILDING		(X3) DATE SURVEY COMPLETED C 07/01/2021		
		B. WING				
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
TALAHI	NURSING AND REHA	BCENTER	VERSITY DF .OUD, MN 5	RIVE SOUTHEAST 6304		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLE DATE	
2 900	Continued From pa	age 7	2 900			
	update the medical	l provider after a pressure		same deficient practice:		
	ulcer was initially observed and failed to ensure			Residents in our building who are at risl	< l	
	appropriate interventions were communicated to			via the Braden Assessment have the		
	all necessary caregivers following the			potential to be affected by the same		
	development of the	e stage 2 pressure ulcer to		deficiency. Residents who have a Brade	en	
	prevent potential for worsening of the ulcer.			identifying at risk have had their care		
				plans reviewed for further intervention.		
	Findings include:			Weekly Skin Checks have been review	ed	
				for new skin alterations.		
	R1's admission Minimum Data Set (MDS), dated					
	5/21/21, identified R1 had been admitted on			What measures will be put into place, o	r	
	5/14/21 related to cellulitis (a serious bacterial infection of the skin). R1 had moderately impaired			systemic changes made, to ensure the		
		nosis of intellectual disability,		deficient practice will not recur: The baseline care plan will be complete	d	
		npliance, diabetes (DM),		to its entirety and will be reviewed by ID		
		irments and multiple cardiac		Braden scores will be reviewed upon	••	
		DS identified R1 required		completion by the IDT team and		
		assist with activities of daily		intervention will be implemented as		
		perienced frequent		needed. Education is provided to licens	ed	
	incontinence of bot	h bowel and bladder. Further,		nurses surround identification of resider	nts	
		pressure ulcer development.		at increased risk for developing pressur	е	
		1's skin were reported at that		injuries, prompt documentation of new		
	time; however, he had treatments as follows:			wounds, provider notification and updat	ing	
		device in chair, application of		care plan/ Kardex with preventative		
		nd ointment/medications to		interventions.		
		s feet. In addition, R1 received tic medication, along with the		How that facility will monitor its correctiv		
	use of oxygen.	ac medication, along with the		actions to ensure that the deficient	/e	
	use of oxygen.			practice is being corrected and will not		
	R1's admission MD	S Care Area Assessments		recur:		
	(CAAs) identified the following information:			The facility will audit weekly wound rour	nds	
	- Nutritional Status, dated 5/24/21: R1 had			and at-risk residents with a Braden sco		
	"Potential for alteration in nutritional status related			at risk and to validate that new wound(s		
		ody mass index] and orders to		are identified timeline, providers update		
		tic diet." The section labeled		and care plan/Kardex are updated. The	se	
		d condition that can affect		audits will be completed weekly x 2		
		ad an available option for		months. Completed audits will be broug	ht	
		juries;" however, this remained		to QAPI for review to determine if any	, c	
		ections to "See active		changes are needed, to extend the time	e ot	
	ulagnosis list. See	nursing pain assessment." The		the audits, or to discontinue.		

2RH711

	ta Department of Hered to the temperature of Hered temperature of the temperature of tem	(X1) PROVIDER/SUPPLIER/CLIA				SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	00614		B. WING			, 1/2021	
NAME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE			
		1717 UN					
	IURSING AND REHA	ABCENTER	LOUD, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE	
2 900	Continued From pa	age 8	2 900				
	overall objective fo	r care planning was to					
	"Maintain current level of functioning" and R1 would continue to be monitored and care planned on.		Ł	The date that each deficie corrected: 8/3/2021	ency was		
	- Pressure Ulcer/In "Actual" problem re	ijury, dated 5/26/21: R1 had ar elated to an existing pressure	1	and date by an official fac			
		actors were identified;		representative			
		h R1 needed a "special ushion to reduce or relieve		Responsible Party: Director of Nursing or De	aianaa		
		ith, immobility, incontinence,		Director of Nursing of De	signee		
		us, cognitive loss, diabetes,					
		ease, pain, having been newly	,				
		g devices that could cause					
		oxygen. The CAA's impact of					
		on R1 and the rationale for					
		ninimize risks" recorded the					
		ated to resident [R1] being at					
		down related to urinary					
		eased mobility, DM, open					
		emities and buttocks present					
	on admission. Treatment in place and areas on lower extremities are healing. Skin is observed with AM/HS [morning and ovening] cares and with		h				
	with AM/HS [morning and evening] cares and with bath. Staff assist him with repositioning in bed he						
		all adjustments independently					
		See assessments, MAR/TAR					
		eatment administration records	5]				
	-	s. Will care plan." The CAA's	-				
		Disciplines remained blank of					
	any referral information.						
		nce and Indwelling Catheter,					
		had this "CAA triggered related	3				
		nce with toileting and					
		as been using his urinal with ontinence, he needs assist					
		bileting not able to complete					
		dependently. Open area noted					
		admission, barrier creams					
		o offer toileting with rounds and	d				
		ee POC [point of care] charting					

Minnesota Department of Health STATE FORM

2RH711

If continuation sheet 9 of 24

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00614	B. WING		C 07/01/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	NURSING AND REHA		IVERSITY DRI LOUD, MN 56	VE SOUTHEAST 304		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	age 9	2 900			
	and progress notes	s. Will care plan."				
	hydration program delegated to Regis order lacked any sp dietitian. - 5/26/21: "Ensure turned/repositioned Document refusals evidence of a turnin order prior to 5/26/2 R1's TARs, May an following order: - 5/26/21: "TO COO foam dressing daily	d/off-loaded every 2 hours. e every shift." The MARs lacked ng/repositioning/off-loading				
	5/27/21. R1's Hospital Sum	ted to perform the treatment or mary, dated 5/14/21, identified				
	extremity cellulitis. related to pressure Pre-Placement Re compiled informatic identified a wound 5/10/21 that reported	gnosis included right lower The summary lacked details a ulcer(s). R1's Discharge port was reviewed which on from his hospital stay and nurse progress note dated ed R1 had bilateral lower ulcerations within the gaiter				
	(area extending fro to below the knee) the report lacked e skin alteration(s), i.	om just above the ankle region area of both legs; however, vidence R1 had any additional .e. pressure ulcer(s), noted l/or upon discharge.				
		reener - V3, effective date a Skin Observation section had	k			

TATEMEI	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00614	B. WING		C 07/01/2021	
AME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
TALAHI	NURSING AND REHA		IVERSITY DRIN LOUD, MN 563	VE SOUTHEAST 304		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMPLE THE APPROPRIATE DATE	
2 900	Continued From pa	age 10	2 900			
	director of nursing two skin alterations leg and one on his admission screene been admitted with pressure ulcer(s) a comprehensive ski R1's Skin & Wound the following inform - Effective date 5/1 with an abrasion to (associated with im legs in a person wi diabetic ulcer to his ulcer to his right sh section labeled "Ac the following interve "Moisture Control," supplementation." presented additional interventions such mattresses, foot cr heel suspension/pr turning/repositionin all remained unche evaluations identifie provided options for resident/responsibl disciplines; all rema - Effective date 5/2 continued to have a alterations; howeve date to have a "Sta loss with exposed of coccyx (area at the pressure ulcer. The	4/21: R1 had been admitted his left foot, a diabetic ulcer paired circulation of the lower th diabetes) to his left calf, a s left shin, and another diabetic in. Each evaluation had a lditional Care" which identified entions: "Moisture barrier," "Nutrition/dietary The Additional Care sections al option choices for as preventative cushions/bed adle, customized shoe wear, otection device, mobility aid(s) g program, and "other" which ecked. In addition, the ed a "Notifications" section tha ir the practitioner, e party, dietician, and therapy	,			

	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	OF CORRECTION	IDENTIFICATION NOWBER.	A. BUILDING:			FLETED
		00614	B. WING		C 07/01/2021	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	NURSING AND REHA	R CENTER 1717 UN	IVERSITY DRI	VE SOUTHEAST		
		SAINT C	LOUD, MN 56	304		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT		(X5) COMPLET
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	DATE
2 900	Continued From pa	age 11	2 900			
	ulcer measured 5.4	centimeters (cm) long by 4.8				
		nd bed had 20 percent (%)				
		er of skin) coverage, along				
		slough (dead tissue). The				
		ection indicated the following				
		sture barrier," "Moisture				
		hion." No other additional care d and the "Notification" section				
	remained uncheck					
		/21: R1's "Stage 2" coccyx				
		asured 4.9 cm long by 4.1 cm				
		ed had 100% slough with a				
	"moderate" amoun	t of "serous (thin, watery and				
		th no odor. The pressure ulcer				
		The "Additional Care" section				
		d moisture barrier and control,				
		/dietary supplementation, in				
		/repositioning program"				
	section remained u	en checked. The "Notification"				
		/21: R1's "Stage 2" coccyx				
		asured 3.5 cm long by 2.6 cm				
		ed had 10% granulation (new				
		with 90% slough and had				
		mount of serous drainage				
		pressure ulcer had been				
		tional Care" section indicated				
		barrier and control and a				
		ation no longer indicated the				
		rning and repositioning				
		n/dietary supplementation. The on remained unchecked.	,			
		7/21: R1's "Stage 2" coccyx				
		asured 3.1 cm long by 2.5 cm				
		ed continued to have 10%				
		% slough with no odor;				
		ate" amount of serous				
		d. The pressure ulcer had beer	า			
		tional Care" section indicated				
	continued moisture	e barrier and control and a				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COM	E SURVEY PLETED C
		00614	B. WING		07/	01/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
TALAHI I	NURSING AND REHA	BCENTER	VERSITY DRI LOUD, MN 56	VE SOUTHEAST 304		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
2 900	Continued From pa	ge 12	2 900			
	remained unchecke - On 6/23/21, R1 ha V5.0 completed for however, R1's med the "Stage 2" coccy evaluated that day. R1's Braden Scale Risk (Braden), effer R1 was slightly limit meaningfully to pre an occasionally mo was exposed to mo physical activity, wa to change and cont adequate pattern of potential problem in shearing. The Brad	ad Skin & Wound Evaluations his lower leg skin alterations; ical record lacked evidence for Predicting Pressure Sore ctive date 5/14/21, identified ted in his ability to respond ssure-related discomfort, had ist degree to which his skin pisture, walked occasionally for as slightly limited in his ability rol his body position, had an f food intake, and had a n relation to friction and en indicated a score of 17 R1 at a "Mild Risk" for				
	completed for R1 o 6/11/21. These Bra- scores of 13 and 14 "Moderate Risk" for The medical record initiated and/or adju interventions in resp pressure ulcer risk Braden assessmen	ponse to R1's increased based on these completed t.				
	undated, had chec occasional urinary i and had "Current sl section labeled "Sp remained blank. Th	Plan/Evaluation - V8, kmarks that identified he had ncontinence, was diabetic, kin integrity issues." The ecify skin integrity issues" we section labeled "Skin are" identified a checked				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _		- (X3) DATE SURVEY COMPLETED	
		00614	B. WING		C 07/01/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
TALAHI	NURSING AND REHA	BCENTER	IVERSITY DRI LOUD, MN 56	VE SOUTHEAST 304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
2 900	Continued From pa	age 13	2 900			
	will be free of comp related to my skin a date" with "Interver medications as ord moisturized with lot extremities. Elevate "Risk for skin break checkmarks. The s "Dietary/Nutritional diet order for "cons regular liquids" and current weight. The was at risk for pote related to his diagn section did not ider alteration(s) or nutr Further, the baselir of specific skin inter interventions to add managing urinary in that addressed turr his impaired mobili	Status" indicated R1 had a distent carbs, regular textures, a dietary goal to maintain his dietary section indicated he entially altered nutritional status dosis of diabetes. The dietary ntify concerns related to skin rition/dietary supplementation. he care plan lacked evidence egrity issues or specific dress them, approaches for ncontinence, or interventions hing and repositioning due to ty.				
	following informatic - Effective date 5/2 skin alteration(s). - Effective date 5/2 skin alterations(s).	Check - V3's identified the on: 0/21: lacked evidence R1 had 7/21: lacked evidence R1 had /21: R1 had a pressure ulcer				
	front lower leg, left leg. The skin check measurements or o skin check identifie alterations identifie	three vascular ulcers; right front lower leg, right rear lower ( lacked the pressure ulcer observations. In addition, the ed R1 had "No" new skin d. /21: lacked evidence R1 had	r			

STATE FORM

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	of connection	IDENTIFICATION NOWBER.	A. BUILDING:			
		00614	B. WING			C 01/2021
NAME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	·	
	URSING AND REHA	BCENTER	-	VE SOUTHEAST		
		SAINT C	LOUD, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 900	Continued From pa	age 14	2 900			
2 300	pitting edema to bil - Effective date 6/1 on his coccyx and t check lacked evide measurements or o skin check identifie alterations identifie - Effective date 6/1 on his coccyx and t check lacked the p or observations. In identified R1 had "N identified. R1's comprehensiv following informatio - Initiated on 6/8/21 Mellitus" with interva alterations and treat doctor and to moni- any signs and sympla- areas. - Revised on 6/9/21 integrity r/t [related ulcer, and bilateral with a goal "I will be minimized pain rela- through the review identified which we	ateral lower legs. 0/21: R1 had a pressure ulce three vascular ulcers. The skin ence of the pressure ulcer observations. In addition, the ed R1 had "No" new skin d. 7/21: R1 had a pressure ulce three vascular ulcers. The skin ressure ulcer measurements addition, the skin check No" new skin alterations	r n n d			
	adjustments made due to venous insu treatments as orde "Blue Pressure relie transferring." - Revised on 6/24/2	on 6/4/21 to elevate his legs fficiency, administer his red, and directed staff to apply eving boots on outside of 21: "The resident has potential				
	wounds," which lac nutrition/dietary sup	al status r/t DM, Obesity and ked evidence of oplementation or specific s to address R1's wounds.				

IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	IDEINTI IOATION NOWIDER.	A. BUILDING:			
	00614	B. WING		C 07/01/2021	
PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
NURSING AND REHA	BCENTER				
SUMMARY STA		· · ·		ORRECTION	(X5)
		PREFIX TAG	CROSS-REFERENCED TO T	HE APPROPRIATE	COMPLET DATE
Continued From pa	age 15	2 900			
risk for pressure ul development and in his risk for pressure than the placement boots. In addition, t R1 had a risk for bo and interventions to risk factors. R1's Kardex [nursing]	cer/skin alteration nterventions to help decrease e ulcer development, other t of blue pressure relieving the care plan lacked evidence owel and bladder incontinence o help decrease associated ng assistant plan of care],				
R1. R1's Kardex la he had skin alterati interventions for sk nutrition supplement and/or wheelchair of	boots outside of transferring cked evidence that identified ions and further lacked in alteration management i.e. ntation, pressure relieving bed cushion, toileting plan,				
identified the follow - 5/18/21, at 8:17 a R1 had vascular we extremities in which adequate to suppo- dietary recommend - 5/30/21, at 9:24 a Orders-Administration director of nursing is 100% slough, no small amount of se edges are red." - 6/10/21, at 2:38 p Administration Note practical nurse (LP care, passed onto	ving entries: m. a dietitian entry identified ounds to bilateral lower h his "current intake is rt healing" and that no new dations were given at that time m. identified an tion Note entered by the (DON); "Bed of coccyx wound pain during dressing change, erous drainage with no odor, m. identified an Orders- e entered by a licensed N); "missed wound [coccyx] PM's."				
	OF CORRECTION PROVIDER OR SUPPLIER SUMMARY ST/ (EACH DEFICIENC REGULATORY OR I Continued From particle - The care plan lac risk for pressure uld development and in his risk for pressure uld development and in his risk for pressure than the placement boots. In addition, for R1 had a risk for br and interventions to risk factors. R1's Kardex [nursing printed 6/30/21, dir pressure relieving I R1. R1's Kardex la he had skin alterative interventions for skin nutrition supplement and/or wheelchair of incontinence care, program. R1's progress note identified the follow - 5/18/21, at 8:17 a R1 had vascular we extremities in which adequate to suppon dietary recomment - 5/30/21, at 9:24 a Orders-Administration small amount of se edges are red.'' - 6/10/21, at 2:38 p Administration Note practical nurse (LP care, passed onto	OF CORRECTION       IDENTIFICATION NUMBER:         00614       00614         PROVIDER OR SUPPLIER       STREET A         NURSING AND REHAB CENTER       1717 UN SAINT C         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       SUMMARY STATEMENT OF DEFICIENCIES         Continued From page 15       - The care plan lacked further evidence R1 had a risk for pressure ulcer/skin alteration development and interventions to help decrease his risk for pressure ulcer development, other than the placement of blue pressure relieving boots. In addition, the care plan lacked evidence R1 had a risk for bowel and bladder incontinence and interventions to help decrease associated risk factors.         R1's Kardex [nursing assistant plan of care], printed 6/30/21, directed staff to apply the blue pressure relieving boots outside of transferring R1. R1's Kardex lacked evidence that identified he had skin alterations and further lacked interventions for skin alteration management i.e. nutrition supplementation, pressure relieving bed and/or wheelchair cushion, toileting plan, incontinence care, or a turning/repositioning program.         R1's progress notes, dated 5/14/21 - 6/26/21 identified the following entries: - 5/18/21, at 8:17 a.m. a dietitian entry identified R1 had vascular wounds to bilateral lower extremities in which his "current intake is adequate to support healing" and that no new dietary recommendations were given at that time. - 5/30/21, at 9:24 a.m. identified an Orders-Administration Note entered by the director of nursing (DON); "Bed of coccyx wound is 100% slough, no pain during dressing change, small amount of serous drainage with no odor,	OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING:         00614       B. WING	OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING:         00614       B. WING         PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         SUMMARY STATEMENT OF DEFICIENCIES       ID         I(EACH DEFICIENCY MUST BE PRECIDEDES       ID         REGULATORY OR LSC IDENTIFYING INFORMATION       ID         PREFICE       PROVIDER'S PLAN OF CONSTRUCTION OF DEFICIENCIES         I(EACH DEFICIENCY MUST BE PRECIDED BY FULL       ID         REGULATORY OR LSC IDENTIFYING INFORMATION       ID         PROVIDER'S PLAN OF CONSTRUCTION OF DEFICIENCIES       ID         Continued From page 15       2 900         - The care plan lacked further evidence R1 had a risk for pressure ulcer development, other than the placement of blue pressure relieving boots. In addition, the care plan lacked evidence R1 had a risk for bowel and bladder incontinence and interventions to help decrease associated risk factors.         R1's Kardex lacked evidence that identified he had skin alteration management i.e. nutrition supplementation, pressure relieving bed and/or wheelchair cushion, toileting plan, incontinence care, or a turning/repositioning program.         R1's progress notes, dated 5/14/21 - 6/26/21         identified the following entries:         -5/30/21, at 9.24 a.m. identified an Orders-         -5/30/21, at 9.24 a.m. identified an Orders-         Addition, the care ging acking drasing change, small amount of serous drainage with no o	OF CORRECTION     IDENTIFICATION NUMBER:     A BUILDING:

If continuation sheet 16 of 24

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED
		00614	B. WING		07/	01/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
TALAHI I	NURSING AND REHA	B CENTER	/ERSITY DRI OUD, MN 56	VE SOUTHEAST 304		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
2 900	Continued From pa	ge 16	2 900			
	admitted for seizure like activity and unresponsiveness. Review of R1's progress notes lacked any other additional entries related to his coccyx pressure ulcer.					
	support a "stage 2" been present upon pressure ulcer indic the medical record medical provider(s) pressure ulcer after lacked that R1 had assessment perforn related to R1's pres and after the "stage initially documented record lacked evide intervention(s) to su pressure ulcer deve	dical record lacked evidence to coccyx pressure ulcer had admission, prior to the first eation on 5/26/21. In addition, lacked evidence that the were updated concerning the development. Further, it a comprehensive skin med which identified all factors sure ulcer risk on admission e 2" pressure ulcer had been d. Furthermore, the medical ence R1 had care planned upport a decreased risk for elopment or to help decrease s related to the documented essure ulcer.				
	nursing assistant (N been aware that R1 coccyx. NA-A ackno Kardex for resident on how to care for t aware of any sort o	on 6/30/21, at 12:03 p.m. NA)-A acknowledged having had sores on his legs and owledged she reviewed the information and interventions hem. NA-A had not been f repositioning or toileting plan ated she would use pillows to				
	get off of his bottom directed his toileting needed to assist hin NA-A had been uns wheelchair and/or r mattress. After NA-	hen she encouraged "him to n." Further, NA-A stated R1 g programming and she m physically at those times. sure if R1 used a cushion in his equired a specialized A reviewed R1's Kardex, she not say," when questioned				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		00614	B. WING		07/	01/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY, S	TATE, ZIP CODE		
	NURSING AND REHA		VERSITY DRI LOUD, MN 56	VE SOUTHEAST 304		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE AC			ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 900	Continued From pa	ge 17	2 900			
	concerning R1's pro	essure ulcer interventions.				
	p.m. licensed pract recollected having l admitted that he having l admitted that he having l not recollect if he having pressure ulcer on h had thought the coor since he got here;" better; however, la mentioned, "not s [pressure ulcer] rea explained R1 initial of bed and he had a right side due to his LPN-B confirmed ti completed on resid and repositioning p "We do rounds eve explained if a reside	interview on 6/30/21, at 12:42 ical nurse (LPN) - B stated she been updated when R1 id cellulitis; however, she could ad been admitted with a is coccyx. LPN-B stated she ccyx ulcer had gotten "worse before it started to "get slightly ter in the interview, LPN-B sure thinking back if it illy got better." LPN-B ly did not desire to get up out a preference for lying on his is wish to face the television. ssue tolerance testing was not ents to help determine turning rograms and further stated, ry two hours." LPN-B ent had a change in condition for would be updated by change.				
	1:39 p.m. the interin denied knowledge to with a pressure ulco interim role at the ti she explained she impression" staff has	by telephone on 6/30/21, at m wound care nurse LPN-A that R1 had been admitted er as she had not been in her me of his admission; however had been "under the ad been aware that R1 had a udmission when staff				
	questioned the lack R1's medical record the date staff broug voiced when a resid receive a head to to registered nurse (R identified then they	t of a pressure ulcer picture in d. LPN-A had been unsure of pht this to her attention. LPN-A dent was admitted they would be skin assessment by a N). If a pressure ulcer was were expected to ensure the ed treatment, was documented				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00614	(X2) MULTIPLE A. BUILDING: _ B. WING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 07/01/2021	
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, S IVERSITY DRI	VE SOUTHEAST		
FALAHI	NURSING AND REHA	BCENTER	LOUD, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLET DATE
2 900	Continued From pa	age 18	2 900			
	the medical record, taken, and then the "wound documental identification. She e skin assessment w screener assessme a separate compre form. When question tolerance identifical nursing performed When questioned of and repositioning p stated that if a reside practice it is every to abnormalities" were initiate or adjust off based on the reside she expected reside check by the cart n form would identify replied "I would imal should have been i checks if it had been evaluations. She e not expected to ador measurements as " abnormalities] weet R1's medical provide regarding his coccy admission and exp in her interim role at During interview on nurse RN-B stated been noted in R1's 5/21/21] when she MDS on 5/27/21 ar wrote R1's pressure	screener assessment" and in , an accompanying picture was a pressure ulcer would have ation every week" following it's explained the comprehensive ras located in the admission ent and the facility did not have hensive skin assessment oned on the facility's tissue tion process, LPN-A denied this type of determination. On how a resident had a turning rogram identified, LPN-A dent were at risk "in my two hours" and if "any [skin] e observed then they "would floading or repositioning" ent's risk factors. LPN-A stated ents would have a weekly skin urses in which the skin check "any skin abnormalities" and agine" R1's pressure ulcer dentified on his weekly skin en present during the explained the cart nurses were d the skin abnormality "we measure [the kly." LPN-A denied knowledge der had been updated /x pressure ulcer since his lained again she had not been at the time of his admission. A 6/30/21, at 2:33 p.m. MDS R1's pressure ulcer had not medical record [on or before had completed R1's admissior of she explained when she had e ulcer CAA the case manager the pressure ulcer had been				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _		Сом	E SURVEY PLETED C
		00614	B. WING		07/01/2021	
AME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
ALAHI	NURSING AND REHA	B CENTER	IVERSITY DRI LOUD, MN 56	VE SOUTHEAST 304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
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	information was ad the purpose of the their [the residents] care of the person RN-B confirmed sh planning process; h did not determine re that was a case ma she had been unsu resident repositioni performed tissue to When interviewed h a.m. the ADON cor admission an RN c assessment in whice abnormalities "right identification, to sup facility acquired, an weekly wound roun admission a reside help determine pre- interventions would calculated score, al risk factors and nee the skin section in t assessment went " factors." She denie resident tissue toler a resident's individu turning/repositionin intervention and sh at risk they would b repositioned "every sacral coccyx ulcer much as you can." alteration(s) observ	by telephone on 7/1/21, at 9:07 firmed upon a resident's ompleted a head to toe skin ch they documented any away," along with photo oport the abnormality was not d then followed up weekly with ds. The ADON explained upor nt had a Braden completed to ssure ulcer risk in which be based off of the Braden's ong with individual resident eds. In addition, she explained he admission screener a little more in-depth with risk d the facility performed rance testing to help determine				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED	
		00614	B. WING	B. WING		C 07/01/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
TALAHI	NURSING AND REHA		IVERSITY DRI LOUD, MN 56	VE SOUTHEAST 304			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)	
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2 900	Continued From pa	age 20	2 900				
	She stated it was "n R1's weekly skin ch on [R1's] skin." The pressure ulcer had admission; "That du The ADON stated F redness upon adm observed again dur weekly wound roun explained the press [the admission redu the ulcer "was prett to determine treatm "pretty stable.". T medical provider ha pressure ulcer in w documentation in h conversation with th further verbalized F wheelchair upon ac with an air mattress repositioning plan w She also was "prett on nutrition/dietary [upon admission] fo prevent any new ul these interventions plan, along with a c identified his skin at ADON stated the in skin alteration risk pressure ulcer shop pulled to the Karde nursing assistants interventions. The <i>k</i> know R1's risk fact alterations and inte how to care for him	nds for skin alteration locations not acceptable" that some of hecks "missed the information e ADON confirmed R1's coccys not been present on eveloped after he got here." R1 had "blanchable [coccys] ission" which had not been ring the proceeding week's nds; however, the ADON sure ulcer "got worse from just ness on] admission in which ty sloughy" and became harde nent despite it having been The ADON verbalized R1's ad been updated on his which there should have been his medical record to support a he "triage nurse" and she R1 was given a cushion in his dmission and he was provided s and an every two hour when the ulcer "opened up." ty sure" R1 had been started supplementation "right away" or his venous leg ulcers and to cers. The ADON confirmed a should have been in R1's care care plan section which alteration risk factors. The netrventions related to R1's factors and his current uld be in his care plan so that if ex as once in the Kardex the would then know the ADON explained if staff did not cors and/or current skin erventions they would not know in and he then would have the rioration of his current skin	k r e t				

Minnesota Department of Health           STATEMENT OF DEFICIENCIES           AND PLAN OF CORRECTION           (X1)           IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED C			
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NAME OF F	PROVIDER OR SUPPLIER						
TALAHI I	NURSING AND REHA	BCENTER	LOUD, MN 56	VE SOUTHEAST 304			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
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2 900	Continued From page 21		2 900				
	alterations and/or new skin alteration development.						
	During interview on 7/1/21, at 11:26 a.m. NA-B (a contracted pool staff) stated she was expected to use the Kardex for resident information. She explained the Kardex had "everything I need to know" in order to care for the residents. R1 confirmed she had not worked with R1 prior to his hospitalization on 6/23/21. After NA-B reviewed R1's Kardex, she confirmed the Kardex lacked information R1 had any skin alterations and that the Kardex did not indicate if R1 had a repositioning plan, used interventions such as a cushion in his wheelchair or air mattress, that he had a toileting plan or if he had indication of bowel/bladder incontinence, or any other interventions for toileting. NA-B stated, "If I had to work with him, it [Kardex] does not say I would have to reposition him." Further, NA-B stated if R1 required a repositioning plan, or other interventions, the Kardex should have that information "otherwise he is not getting the care he deserves."		5				
	stated staff would r how to care for a re staff [NAs] to follow they [residents] are Thus, LPN-C expla interventions needed	on 7/1/21, at 11:39 a.m. LPN-C efer to the Kardex to know esident and that she expected what was indicated on it "so getting the proper care." ined resident care ed to be present on the Kardex Further, she stated she					
	expected interventi comprehensive car would be accurate "flow over" to the K R1's Kardex, she c						

Minnesota Department of Health           STATEMENT OF DEFICIENCIES         (X1) PROVIDER/SUPPLIER/CLIA           AND PLAN OF CORRECTION         IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
		DENTIFICATION NOMBER.	A. BUILDING:			
		00614	B. WING			C 01/2021
AME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
	IURSING AND REHA	BCENTER	VERSITY DRIN LOUD, MN 56	VE SOUTHEAST 304		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF			
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLE DATE
2 900	Continued From page 22		2 900			
	decrease skin alter program. LPN-C vo for repositioning if e voiced there was "a not be followed." LF repositioning progra there [the Kardex]" plan itself at least." During interview on director of nursing part of the care pla "execute their dutie she expected the k such as repositionin applicable to the re- interventions. The F resident intervention Kardex there was a any current skin alt review of R1's Kard Kardex lacked evid skin integrity and/o interventions, other stated she expecte assessment to indi on admission, alon comprehensive car factors for skin alter alterations that wer DON explained she comprehensive ass after a new pressur-	a 7/1/21, at 11:52 a.m. the (DON) stated the Kardex was n and is what the NAs used to es" for resident care and thus Kardex to contain interventions ng and toileting plans if esident and any skin alteration DON explained if such specific ins were not identified on the a "risk for pressure injury" and erations may decline. After dex, the DON confirmed R1's lence which instructed staff on r coccyx pressure ulcer than the blue boots. The DON d the admission screener cate all skin alterations noted g with the base line and re plans should address risk erations; not just the skin re present. In addition, the e also expected a new sessment to be completed re ulcer was acquired, along ovider to be updated, in order				
	ensure appropriate	injury or concern" and to wound treatment. Condition, revised 12/19/18,				

Minnesota Department of Health							
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00614	B. WING		07/0	) 1/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
TALAHI	NURSING AND REHA	BCENTER	/ERSITY DR OUD, MN 50	IVE SOUTHEAST 5304			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE	
2 900	Continued From pa	age 23	2 900				
2 900	notified promptly w of a pressure ulcer be documented in care plan would be A policy Care Plan/ indicated its purpos resident received of herself and that the care were commun policy identified the based on the reside medical history and care plan would be the resident's cond SUGGESTED MET The director of nur- all residents at risk they are assessed	hen there had been an onset , in which the notification would the medical record and the updated as necessary. Conference, revised 1/25/21, se was to ensure that each are individualized to him or e goals and approaches for nicated to caregivers. The e comprehensive care plan was ent's medical condition, d assessments, and that the revised as information about	2 900				
Minnesota D	receiving the neces prevent pressure u promote healing of of nursing or desig audits of the asses processes, along w ensure appropriate implemented; to re ulcer development	ssary treatment/services to lcers from developing and to pressure ulcers. The director nee, could conduct random sment and care planning vith the delivery of care; to care and services are duce the risk for pressure					