



Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:

Talahi Nursing & Rehab Center
1717 University Drive SE
St. Cloud, MN 56304
Sherburne County

Report #: H5438036

Date: October 28, 2013

Date of Visit: September 25, 2013
Time of Visit: 8:00 a.m. – 4:00 p.m.

By: Elizabeth Swan, R.N., Special Investigator
Lisa Ciesinski, R.N., Special Investigator

- Type of Facility:**
- Nursing Home
 - SLF
 - Hospital
 - HHA
 - ICF/IID
 - Other: _____
 - Home Care Provider/Assisted Living
 - Home Care

- Facility Self Report
- Complaint

Allegation(s): It is alleged that financial exploitation occurred when staff forged a resident's check.

An unannounced visit was made at this facility and an investigation was conducted under:

- Federal Regulations for Hospital Conditions of Participation (42 CFR, Part 482)
- Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
- Federal Regulations for ICF/IID (42 CFR Part 483, subpart I)
- Federal Regulations for HHA (Home Health Agencies) (42 CFR, Part 484)
- Federal Regulations for CAH (Critical Access Hospital) (42 CFR, Part 485)
- Federal Regulations for EMTALA (42 CFR Part 489)
- State Licensing Rules for Boarding Care Homes (MN Rules Chapter 4655)
- State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
- State Licensing Rules for Supervised Living Facilities (MN Rules Chapter 4665)
- State Licensing Rules for Home Care (MN Rules Chapter 4668)

- State Statutes for Maltreatment of Minors (MN Statutes, section 626.556)
- State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
- State Statutes Chapters 144 and 144A

Conclusion:

Minnesota Vulnerable Adults Act (MN 626.557)

Under the Minnesota Vulnerable Adults Act (MN. 626.557):

Abuse Neglect Financial Exploitation was:

Substantiated Not Substantiated Inconclusive based on the following information:

Based on a preponderance of evidence, financial exploitation occurred when the alleged perpetrator (AP) wrote a check, for \$300.00 with the residents' personal check blank. The AP used the residents' rubber signature stamp to endorse the check. The resident did not give the AP permission to write a check for \$300.00 or to use the residents' rubber signature stamp for endorsement.

The resident was alert and oriented to person, place, and time. Due to the resident's inability to perform the task of writing, the resident used a rubber signature stamp to sign documents including check blanks.

A police report revealed the resident stated a check made out to the AP for \$300.00 was forgery. The resident stated s/he did not approve the check, and that the AP forged the check. The AP admitted to filling out the check and using the residents' rubber signature stamp to endorse the check. The report indicated the AP insisted the resident borrowed the money to go on a trip.

At the time of the onsite visit, the resident stated in an interview that personal items, which included the residents' checkbook and rubber signature stamp, were stored in a bag that hung on the back of the residents' wheelchair. The resident stated the AP took the checkbook, wrote the check, and used the rubber signature stamp for endorsement without the resident's permission. The resident denied borrowing money to the AP.

This investigator tried to contact the AP by telephone. The AP did not return calls nor did the AP respond to a subpoena for a requested interview.

The AP's termination of employment was effective at the time that the resident reported the forged check.

The police forwarded the case to the county attorney's office.

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the individual(s) and/or facility is responsible for the

Abuse Neglect Financial Exploitation. This determination was based on the following:

The facility provided training to the AP regarding the Vulnerable Adult Act and what constituted financial exploitation. The facility had a policy in place that identified staff were not to accept money from residents.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

Compliance:

Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B) – Compliance Not Met
The requirements under the Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B), were not met.

Deficiencies are issued on form 2567: Yes No If no, specify: _____
(The 2567 will be available on the MDH website.)

State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) – Compliance Met
The facility was found to be in compliance with State Licensing Rules for Nursing Homes (MN Rules Chapter 4658). No state orders were issued.

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Met
The facility was found to be in compliance with State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557). No state licensing orders were issued.

State Statutes Chapters 144 & 144A – Compliance Met
The facility was found to be in compliance with State Statutes for Chapters 144 & 144A. No state licensing orders were issued.

Facility Corrective Action:

The facility took the following corrective action(s):
The facility's policy and procedure for Receiving of Gifts from Residents dated 08/02/2011 and reviewed on 09/24/201, included money as gifts that staff are not to accept.

Definitions:**Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated**

"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

Minnesota Statutes, section 626.5572, subdivision 9 - Financial exploitation

"Financial exploitation" means:

(a) In breach of a fiduciary obligation recognized elsewhere in law, including pertinent regulations, contractual obligations, documented consent by a competent person, or the obligations of a responsible party under section 144.6501, a person:

(1) engages in unauthorized expenditure of funds entrusted to the actor by the vulnerable adult which results or is likely to result in detriment to the vulnerable adult; or

(2) fails to use the financial resources of the vulnerable adult to provide food, clothing, shelter, health care, therapeutic conduct or supervision for the vulnerable adult, and the failure results or is likely to result in detriment to the vulnerable adult.

(b) In the absence of legal authority a person:

(1) willfully uses, withholds, or disposes of funds or property of a vulnerable adult;

(2) obtains for the actor or another the performance of services by a third person for the wrongful profit or advantage of the actor or another to the detriment of the vulnerable adult;

(3) acquires possession or control of, or an interest in, funds or property of a vulnerable adult through the use of undue influence, harassment, duress, deception, or fraud; or

(4) forces, compels, coerces, or entices a vulnerable adult against the vulnerable adult's will to perform services for the profit or advantage of another.

(c) Nothing in this definition requires a facility or caregiver to provide financial management or supervise financial management for a vulnerable adult except as otherwise required by law.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

Medical Records

Care Guide

Medication Administration Records

Treatment Sheets

Facility Incident Reports

Physician Progress Notes

ADL (Activities of Daily Living) Flow Sheets

Laboratory and X-ray Reports

Physician Orders

Social Service Notes

Nurses Notes

Meal Intake Records

Activities Reports

Weight Records

Therapy and/or Ancillary Services Records

Assessments

Skin Assessments

Care Plan Records

Other pertinent medical records:

Hospital Records Ambulance/Paramedics Medical Examiner Records Death Certificate

Police Report

Additional facility records:

Resident/Family Council Minutes

Personnel Records/Background Check, etc.

Staff Time Sheets, Schedules, etc.

Facility In-service Records

Facility Internal Investigation Reports

Facility Policies and Procedures

Call Light Audits

Other, specify: _____

Number of additional resident(s) reviewed: 3

Were residents selected based on the allegation(s)? Yes No N/A Specify: _____

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

Yes No N/A Specify: _____

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s): Yes No N/A Specify: _____

If unable to contact complainant, attempts were made on:

Date/time: _____ Date/time: _____ Date/time: _____

Interview with family: Yes No N/A Specify: _____

Did you interview the resident(s) identified in allegation: Yes No N/A Specify: _____

Did you interview additional residents: Yes No

Total number of resident interviews: 8

Interview with staff: Yes No N/A Specify: _____

Tennessee Warning given as required: Yes No

Total number of staff interviews: 3

Physician interviewed: Yes No

Nurse Practitioner interviewed: Yes No

Interview with Alleged Perpetrator(s): Yes No N/A Specify: AP did not return calls or respond to subpoena for interview

Attempts to contact: Date/time: 10/10/13 9:14 a.m. Date/time: 10/17/13 12:00 p.m. Date/time: 10/14/13 9:00 a.m.

If unable to contact was subpoena issued: Yes , date subpoena was issued 10/17/13 No

Were contacts made with any of the following:

Emergency personnel Police Officers Medical Examiner Other: Specify _____

Observations were conducted related to:

- | | | |
|--|---|---|
| <input type="checkbox"/> Wound Care | <input type="checkbox"/> Medication Pass | <input type="checkbox"/> Meals |
| <input type="checkbox"/> Personal Care | <input type="checkbox"/> Dignity/Privacy Issues | <input type="checkbox"/> Restorative Care |
| <input type="checkbox"/> Nursing Services | <input type="checkbox"/> Safety Issues | <input type="checkbox"/> Facility Tour |
| <input type="checkbox"/> Infection Control | <input type="checkbox"/> Cleanliness | <input type="checkbox"/> Injury |

Use of Equipment

Transfers

Incontinence

Call Light

Other: _____

Was any involved equipment inspected: Yes No N/A

Was equipment being operated in safe manner: Yes No N/A

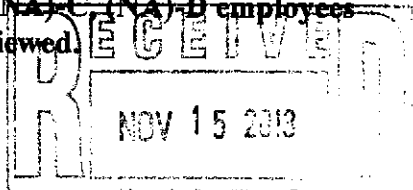
Were photographs taken: Yes No Specify: _____

xc: Division of Compliance Monitoring - Licensing & Certification
Minnesota Board of Examiners for Nursing Home Administration
St. Cloud City Police Department
Sherburne County Attorney
St. Cloud City Attorney

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

NOV 14 2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ MN Dept of Health St.Cloud B. WING _____	(X3) DATE SURVEY COMPLETED C 10/09/2013
NAME OF PROVIDER OR SUPPLIER TALAHI NURSING AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 497 SS=E	<p>An abbreviated standard survey was initiated on September 25, 2013 to investigate complaint #H5438036. The following deficiency is issued:</p> <p>483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE</p> <p>The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to complete performance reviews every 12 months for 4 of 4 [(NA)-A, (NA)-B, (NA)-C, (NA)-D] employees reviewed.</p> <p>Findings include: Nursing assistant (NA)-A's personnel file was reviewed on 9/25/2013, and indicated a hire date of 11/22/2010. The personnel file indicated NA-A's last performance review was completed on 2/2/2012. The facility ended NA-A's employment on 8/14/2013, after allegations of</p>	F 497	<p>F497 Facility failed to complete performance reviews every 12 months for 4 of 4 (NA)-A, (NA)-B, (NA)-C, (NA)-D employees reviewed.</p> <p>Facility will perform performance reviews on all staff every 12 months during the month of their hire. Staffing coordinator will email at the end of each month all department heads a list of staff who's anniversary is coming due the next month. Department head or designee will complete employee reviews of staff during anniversary month annually. Staffing coordinator will audit staff files 10 files a week to ensure compliance. All employee evaluations will be up to date by December 31, 2013</p> <p><i>Nov 18, 2013 per adm director of nursing</i></p>	



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Raymond Dykhuizen* TITLE ADMINISTRATOR (X6) DATE 11-13-2013

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

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

PRINTED: 10/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2013
NAME OF PROVIDER OR SUPPLIER TALAH NURSING AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 497	<p>Continued From page 1 financial exploitation.</p> <p>Nursing assistant (NA)-B's personnel file was reviewed on 9/25/2013, and indicated a hire date of 4/3/2000. The personnel file indicated NA-B's last performance review was completed on 7/12/2012.</p> <p>Nursing assistant (NA)-C's personnel file was reviewed on 9/25/2013, and indicated a hire date of 8/18/2009. The personnel file indicated NA-C's last performance review was completed on 9/8/2011.</p> <p>Nursing assistant (NA)-D's personnel file was reviewed on 9/25/2013, and indicated a hire date of 9/1/2009. The personnel file indicated NA-D's last performance review was completed on 9/20/2011.</p> <p>When interviewed on 9/25/2013 at 1:13 p.m. the director of nursing (DON) stated employee performance evaluations are to be completed annually. The DON confirmed that NA-B, NA-C and NA-D lacked documentation of performance reviews completed in the past year, and when NA-A's employment ended on 8/14/2013, NA-A had not had a performance review completed in 18 months.</p>	F 497			

THE GIBBER
NOV 15 2013
0938

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00614	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/09/2013
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NAME OF PROVIDER OR SUPPLIER TALAH NURSING AND REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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2 000

Initial Comments

2 000

*****ATTENTION*****

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

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

INITIAL COMMENTS:

A complaint investigation was initiated on September 25, 2013 to investigate complaint #H5438036. No correction orders are issued.

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

TITLE

(X6) DATE

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26884, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245438	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 11/18/2013
Name of Facility TALAH NURSING AND REHAB CENTER		Street Address, City, State, Zip Code 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304

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

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

Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
State Agency				
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
CMS RO				

Followup to Survey Completed on: 10/9/2013	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
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