Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 31, 2023

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

RE: CCN: 245438
Cycle Start Date: December 30, 2022

Dear Administrator:

On January 11, 2023, we notified you a remedy was imposed. On January 24, 2023 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 January 23, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective January 26, 2023 did not go into effect. (42 CFR 488.417 (b))

However, as we notified you in our letter of January 11, 2023, 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 is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 26, 2023. 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,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
January 11, 2023

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

RE: CCN: 245438
Cycle Start Date: December 30, 2022

Dear Administrator:

On December 30, 2022, survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMOVAL OF IMMEDIATE JEOPARDY

On December 30, 2022, the situation of immediate jeopardy to potential health and safety cited at F886 was removed. However, continued non-compliance remains at the lower scope and severity of F.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 26, 2023.

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

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective January 26, 2023, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 26, 2023, (42 CFR 488.417 (b)).

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.

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 $11,292; 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.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective January 26, 2023. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same

deficient practice.

- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Karen Aldinger, Unit Supervisor
St. Cloud A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 30, 2023 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS DENIAL OF PAYMENT

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

Steven.Delich@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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

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

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

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

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

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

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

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

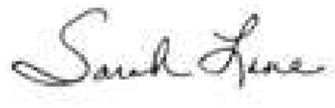
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245438	A. BUILDING _____ B. WING _____	C 12/30/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 12/28/22 through 12/30/22, a COVID-19 Focused Infection Control survey was conducted at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was determined to be NOT in compliance. In addition, a standard abbreviated survey was also conducted. The following complaint was found to be UNSUBSTANTIATED: H54387095C (MN00087739), H54387096C (MN00087034), H54386864C (MN00089403). However, during the investigation, another citation was issued at F886. The survey resulted in an immediate jeopardy (IJ) to resident health and safety. An IJ at F886 began on 12/22/22, when the facility failed to ensure staff were tested for COVID-19 during an outbreak. The administrator, and director of nursing (DON) were notified of the IJ on 12/29/22, at 5:15 p.m. The IJ was removed on 12/30/22, at 2:30 pm. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	F 000		
F 886 SS=L	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement	F 886		1/23/23

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

Electronically Signed | 01/16/2023

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

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F 886	Continued From page 1 and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test.	F 886		

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F 886	Continued From page 2 §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to test all employees for COVID-19 during a facility outbreak status as directed by the Center for Disease Control (CDC). The facility failed to review employee testing logs, and as a result 12 staff members worked with residents during the outbreak without being tested every 3-7 days. Of those 12 staff that have worked with residents but not tested, 3 were not vaccinated and at higher risk of contracting COVID-19 when exposed. This deficient practice resulted in an immediate jeopardy (IJ) situation for all 66 residents residing in the facility during a COVID-19 outbreak. 7 of those residents (R7, R8, R9, R10, R11, R12 and R13) were not vaccinated for COVID-19 and at a higher risk of contracting COVID-19 when exposed and had a higher risk of adverse outcome. 34 residents (R6, R8, R11, R13, R14, R15, R16, R17, R18, R19,	F 886	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth, or the facts alleged, or the conclusion set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required by the provisions of the health and safety code section 1280 and 42CFR 483. This plan of correction constitutes the facility's written credible allegation of compliance. This plan of correction constitutes the facility's written allegation of compliance. F886 Those affected by the deficient practice: • R6, R8, R11, R13, R14, R15, R16, R17, R19, R20, R21, R22, R23, R24, R25, R26, R27, R28, R29, R30, R31, R32, R34, R35, R36, R37, R38, R39,	

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F 886	Continued From page 3 R20 , R21, R22, R23, R24, R25, R26, R27, R28, R29, R30, R31, R32, R33, R34, R35, R36, R37, R38, R39, R40, R41, R42, R43) had contracted COVID-19 between 12/11/22 and 12/27/22, two of those residents were unvaccinated (R8 and R11), and (R6) was hospitalized with COVID-19. The IJ began on 12/11/22, when R13 became positive for COVID-19 and the facility failed to either conduct contact tracing, or ensure all staff were testing every 3 - 7 days during the outbreak as directed by the Center for Disease Control (CDC) and facility policy. The administrator and director of nursing (DON) were notified of the IJ on 12/29/22, at 5:15 p.m. The IJ was removed on 12/30/22, at 2:30 p.m., but noncompliance remained at the lower scope and severity level of F, widespread, which indicated no actual harm with potential for more than minimal harm that was not immediate jeopardy. Findings include: The current Center for Disease Control (CDC) guidance indicated testing with authorized nucleic acid or antigen detection assays was an important addition to other infection prevention and control (IPC) recommendations aimed to prevent COVID-19 from entering nursing homes, detecting cases quickly, and stopping transmission. Swift identification of confirmed COVID-19 cases allows the facility to take immediate action to remove exposure risks to nursing home residents and staff. When one case of COVID-19 is identified, either contact tracing or broad based outbreak testing is required. With broad based testing, all staff would need to be tested every three to seven days until there were fourteen days without a COVID-19	F 886	R40, R41, R42, and R43 have all recovered from Covid-19. • R8 and R11 are unvaccinated for Covid-19 due to declination of vaccine by resident or guardian. To ensure deficient practice does not recur: • The 12 staff identified in the 2567 who had not tested per requirements are now in compliance. • All Staff members received re-education on the requirement to test at least every 7 days while the facility is in outbreak. • New employees will be educated on testing requirements in orientation. • If staff fail to comply with testing requirements, they will be removed from the schedule and not allowed to work until requirement is met. • IDT will review staff schedules and testing logs during morning meeting to ensure staff scheduled to work have and/or will complete testing as required. Monitoring to ensure the deficient practice will not reoccur: • An audit to ensure review of schedules and testing logs occurs in morning IDT will be completed 5x per week for 1 month or until the current facility outbreak is over, whichever occurs last. • The results of audits will be reviewed monthly by the QAPI committee. The committee will determine frequency and duration of audits.	

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F 886	Continued From page 4 positive staff or resident. The facility's policy COVID-19 Testing Plan last revised 12/28/22, indicated upon identification of a single new case of COVID-19, all staff and residents would be tested regardless of vaccination status and testing would continue until there were no new cases for fourteen days. Review of the facility resident COVID-19 positive log indicated the following: On 12/11/22, one resident (R13) was positive for COVID-19. On 12/12/22, five residents (R6, R11, R14, R15, R16) were positive for COVID-19. R6 was sent to the emergency room on 12/19/22, and hospitalized. On 12/14/22, two residents (R17, R18) were positive for COVID+19. On 12/15/22, four residents (R19. R20, R21, R22) were positive for COVID+19 On 12/16/22, one resident (R23) was positive for COVID-19. On 12/17/22, one resident (R24) was positive for COVID-19. On 12/19/22, three residents (R34, R35, R36) were positive for COVID-19. On 12/20/22, one resident (R37) was positive for COVID-19. On 12/22/22, four residents (R38, R39, R40, R41)	F 886		

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F 886	Continued From page 5 were positive for COVID-19. On 12/23/22, on resident (R25) was positive for COVID-19. On 12/24/22, one resident (R26) was positive for COVID-19. On 12/25/22 two residents (R27, R28) were positive for COVID-19 On 12/26/22 four residents (R8, R29, R30, R31) were positive for COVID-19. On 12/27/22 three residents (R32, R42, R43) were positive for COVID-19. The facility's Resident Vaccination log identified the following residents were not vaccinated against COVID-19, therefore at higher risk of adverse outcome if they were to contract the virus: R7, R8, R9, R10, R11, R12, and R13. Review of staff schedules and facility testing logs from 12/11/22, to 12/24/22, indicated 12 staff members had worked without being tested as required. The information about the 12 staff member is as follows: Nursing assistant (NA)-A worked 12/17/22, and 12/18/22, but did not test for COVID-19 for the weeks that began with 12/11/22, and 12/18/22. NA-B worked 12/13/22 and did not test for COVID-19 the week that began 12/11/22. NA-C worked 12/18/22 and did not test for COVID-19 the week that began 12/18/22	F 886		

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F 886	Continued From page 6 NA-D worked 12/12/22, 12/13/22, 12/14/22, 12/15/22, 12/17/22, 12/18/22, 12/19/22, 12/20/22, 12/21/22, 12/22/22, and 12/24/22, but failed to test for COVID-19 the weeks beginning 12/11/22, and 12/18/22. NA-E worked 12/19/22, 12/20/22, and 12/24/22 and failed to test for COVID-19 the week that began 12/11/22. NA-F worked 12/19/22, 12/20/22, 12/23/22, and 12/24/22, but failed to test for COVID-19 the week that began 12/18/22. NA-G worked 12/18/22, but failed to test for COVID-19 the week that began 12/18/22. Licensed practical nurse (LPN)-A worked 12/12/22, 12/13/22, 12/14/22, 12/15/22, 12/16/22, 12/17/22, 12/18/22, 12/19/22, 12/20/22, 12/21/22, 12/22/22, 12/23/22, 12/24/22, but failed to test for COVID-19 the weeks that began 12/11/22, and 12/18/22. LPN-B worked 12/19/22, and 12/23/22, but failed to test for COVID-19 the week that began 12/18/22. Cook (C)-A worked 12/19/22, 12/21/22, 12/22/22, 12/23/22, and 12/24/22, but failed to test for COVID-19 the week that began 12/18/22. The staff vaccination record identified had not been vaccinated for COVID-19. Dietary Aide (DA)-A worked 12/11/22, but failed to test for COVID-19 the week that began 12/11/22. The staff vaccination log identified DA-A had not been vaccinated against COVID-19.	F 886		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245438	A. BUILDING _____ B. WING _____	C 12/30/2022

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

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F 886	Continued From page 7 DA-B worked 12/11/22, 12/13/22, 12/15/22, 12/16/22, 12/17/22, 12/18/22, 12/19/22, 12/21/22, 12/22/22, and 12/24/22, but failed to test for COVID-19 the weeks that began 12/11/22, and 12/18/22. DA-C worked 12/11/22, 12/13/22, 12/15/22, and 12/16/22, but failed to test for COVID-19 the week that began 12/11/22. The staff vaccination log identified DA-C had not been vaccinated against COVID-19. During an interview on 12/29/2022, at 2:47 PM NA-E stated she tested twice a week until she became COVID-19 positive in August. NA-E stated she had not tested the week of 12/11/22 because she had been positive in August, 4 months prior. During an interview on 12/29/2022, at 3:59 PM NA-F stated staff tested every time they came in. NA-F stated she could not remember if she had tested the week that started 12/18/22. When explained what was on the testing log NA-F stated she could not remember why she had not tested that week. During an interview on 12/29/2022, at 4:19 PM NA-C acknowledge testing was done twice a week if you were working. NA-C acknowledge she only worked two times that week so did not test even though she was supposed to. During an interview on 12/29/2022, at 4:29 PM DA-C acknowledged staff should covid test twice a week while in outbreak. DA-C stated he forgot to test the week of 12/11/22. R6's face sheet indicated diagnoses that included	F 886		

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F 886	Continued From page 8 Type two diabetes with ketoacidosis, peripheral vascular disease, hypertensive heart disease, and Acute kidney failure. R6's hospitalization admission history and physical (HP) dated 12/20/22, at 1:05 a.m. indicated R6 had fever of 103 degrees Fahrenheit (F), cough, headache, congestion, and generalized weakness, which contributed to a fall as part of hospitalization. The HP indicated the white blood cell count was normal but did show a "left shift" which indicated an infectious process occurred. R6 was started on Lovenox-injectable blood thinner, due to COVID-19 diagnosis. The hospital records identified R6 was admitted on 12/20/22 and returned to the facility on 12/23/22 with a diagnosis of COVID-19. During an interview on 12/29/22, at 12:03 p.m. the director of nursing (DON) stated she was also the infection preventionist (IP) for the facility and was in charge of COVID testing. The DON acknowledge they did not do contact tracing but started facility wide testing right away. The DON stated there was a table at the employee entrance with testing supplies, and a sign that stated all staff needed to test weekly due to facility being in outbreak status. The DON acknowledge that testing was done by staff and nobody oversaw to make sure each staff working actually got tested. There was no tracking to ensure that happened. The DON reviewed the COVID-19 testing log and the staff schedule from 12/11/22, to 12/24/22, and acknowledge that 12 staff members had worked around residents in that time period and had not tested according to policy. The DON stated all 12 staff should have tested at least weekly.	F 886		

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F 886	Continued From page 9 During interview on 12/29/22, at 2:48 p.m. the administrator stated her expectation was that all staff tested according to facility policy while in outbreak status. The IJ which began on 12/11/22, was removed on 12/30/22, at 2:30 p.m. when it could be verified through observation, interview and document review the facility had tested all their employees to ensure all employees had a verified negative COVID-19 test result prior to the start of their shift. Administration had trained all employees on COVID-19 test requirements. Policies were reviewed and revised to reflect protocols for testing procedures and tracking to ensure all staff were tested for COVID-19 in a manner consistent with current standards of practice for conducting and tracking COVID-19 tests; Education was provided to all staff on current and updated COVID protocols for staff and would continue for continued outbreak testing; and completion of testing and training would be tracked, analyzed, and acted on to ensure compliance with routine and outbreak testing.	F 886		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 11, 2023

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

Re: Event ID: M7H011

Dear Administrator:

The above facility survey was completed on December 30, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00614	A. BUILDING: _____ B. WING _____	C 12/30/2022

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2 000	Initial Comments *****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: On 12/28/22 to 12/30/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaints were found to be UNSUBSTANTIATED: H54387095C	2 000		

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2 000	Continued From page 1 (MN00087739), H54387096C (MN00087034), H54386864C (MN00089403). Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		