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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: VHT6

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00614

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245438**
2.STATE VENDOR OR MEDICAID NO.
(L2) **885463000**

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

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **06/01/2013**

6. DATE OF SURVEY **11/30/2021** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **77** (L18)
13.Total Certified Beds **77** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	77			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
James Anderson SFM 12/01/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 12/01/2021 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/23/2021
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 1, 2021

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

RE: CCN: 245438
Cycle Start Date: October 12, 2021

Dear Administrator:

On November 3, 2021, we informed you of imposed enforcement remedies.

On November 30, 2021, the Minnesota Department Public Safety completed a revisit and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

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

K0321 -- S/S: D -- NFPA 101 -- Hazardous Areas - Enclosure Bld: 01
K0324 -- S/S: D -- NFPA 101 -- Cooking Facilities Bld: 01
K0345 -- S/S: F -- NFPA 101 -- Fire Alarm System - Testing And Maintenance Bld: 01
K0353 -- S/S: F -- NFPA 101 -- Sprinkler System - Maintenance And Testing Bld: 01
K0901 -- S/S: F -- NFPA 101 -- Fundamentals - Building System Categories Bld: 01
K0914 -- S/S: F -- NFPA 101 -- Electrical Systems - Maintenance And Testing Bld: 01
K0916 -- S/S: F -- NFPA 101 -- Electrical Systems - Essential Electric Syste Bld: 01

As a result of the revisit findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 18, 2021, will remain in effect.

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

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 18, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 18, 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.

As we notified you in our letter of November 3, 2021, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 18, 2021.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

DEPARTMENT CONTACT

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

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

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 April 12, 2022 (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

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

Tamika.Brown@cms.hhs.gov

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

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

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

INFORMAL DISPUTE RESOLUTION/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: VHT6

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00614

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245438**
2.STATE VENDOR OR MEDICAID NO.
(L2) **885463000**

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

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **06/01/2013**

6. DATE OF SURVEY **10/12/2021** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **77** (L18)
13.Total Certified Beds **77** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	77			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Nicole Sassen, HFE - NE II 11/16/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 11/18/2021 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically Submitted
November 3, 2021

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

RE: CCN: 245438
Cycle Start Date: October 12, 2021

Dear Administrator:

On October 12, 2021, 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 October 12, 2021, the situation of immediate jeopardy to potential health and safety cited at F 886 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 November 18, 2021.

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 November 18, 2021, (42 CFR 488.417 (b)), (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 18, 2021, (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 $11,160; 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.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective November 18 , 2021. 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" tag), and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Judy Loecken, 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: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

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 April 12, 2022 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS DENIAL OF PAYMENT

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

Tamika.Brown@cms.hhs.gov

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

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program

Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

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

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

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

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

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

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited

deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: 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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification

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 10/12/2021

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
E 000	Initial Comments On 10/4/21-10/12/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator	E 041		11/12/21

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

Electronically Signed | 11/05/2021

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E 041	Continued From page 1 must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the	E 041		

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E 041	Continued From page 2 availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to monitor the emergency generator in accordance with the NFPA 99 " Healthcare Facilities Code" 2012 edition, section 6.4.1.1.17.	E 041	All residents have the potential to be affected. A remote annunciator for the generator has been ordered on 11/3/2021 from	

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E 041	Continued From page 3 This deficient practice could have a widespread impact on all residents within the facility. Findings include: On 10/05/2021, at 11:08 a.m. during the facility tour, observations revealed that the facility did not have a remote annunciator panel installed for monitoring the operating status of the facility's emergency generator at any locations outside of the generating room or in any locations readily observed by operating personnel at a regular work station. This deficient condition was verified by the Maintenance Supervisor.	E 041	Allied Generator. Equipment will be installed by an electrician and Allied Generator will connect the part once it arrives at facility. Charge nurses on duty, Manager On Duty, on-call RN or whomever is always assigned as charge will be educated on reading the remote annunciator panel for the generator. Annunciator panel will only alarm if there is a performance issue. Those that are identified as Charge nurses on duty, Manager On duty, on-call RN or whomever is always assigned as "charge" are to notify Maintenance if annunciator panel is alarming. Maintenance will work staff though steps to correct, or come on site to fix generator, or notify the service company of errors. Annunciator panel will be check weekly by maintenance staff to ensure it is functioning properly and generator performance is working at optimal levels. Weekly audits will be conducted for four weeks, then monthly for one month. Audit results to be reviewed at monthly QAPI to evaluate the effectiveness of remote annunciator of the generator and the need for audit continuation. Adm/Director of Environmental Services or designee is responsible for ensuring compliance. Corrective Date of Compliance: 11/12/2021	
F 000	INITIAL COMMENTS On 10/4/21-10/12/21, a standard recertification	F 000		

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F 000	Continued From page 4	F 000		

survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.

The following complaints were found to be SUBSTANTIATED:
H5438126C (MN75173), H5438128C (MN76957), however NO deficiencies were cited due to actions implemented by the facility prior to survey:

The following complaints were found to be UNSUBSTANTIATED:
H5438125C (MN74292)
H5438127C (MN76878)
H5438130C (MN77080)

The following complaints were found to be UNSUBSTANTIATED, however related deficiencies were cited.
H5438129C (MN75646), with a deficiency cited at F610.

The survey resulted in an Immediate Jeopardy (IJ) at F886 when the facility failed to test staff for COVID-19 according to county transmission rate, and outbreak status as directed by the Center for Disease Control (CDC). The facility was in COVID-19 outbreak status since 9/17/21 which resulted in four staff testing positive for COVID-19. This practice resulted in an IJ situation which had the likelihood to cause serious illness or death for all 67 residents residing in the facility.

The immediate jeopardy began on 9/17/21, when the facility was notified a staff member tested positive for COVID-19. The immediate jeopardy

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F 000	Continued From page 5 was removed on 10/12/21, at 10:30 a.m. but noncompliance remained at the lower scope and severity level of F, which indicated widespread scope, and no actual harm with potential for more than minimal harm that was not immediate jeopardy. 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. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to assess the practice of self-administration of medications was safe for 1 of 1 resident (R38) observed to self-administer a nebulized medication. Findings included: R38's admission Minimum Data Set (MDS), dated 9/10/21, indicated R38's cognition was severely	F 554	R38 had a planned discharge from the facility on 10/21/2021. All residents have the potential to be affected. All Residents have been reviewed to determine if they desire to self-administer medications or who have inhaled medication.	11/12/21

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F 554	Continued From page 6 impaired. R38's face sheet, dated 10/7/21, noted R38's diagnoses included Alzheimer's Disease, dementia, and shortness of breath. R38's medication list signed by her provider on 10/6/21, noted R38 had an order to receive Ipratropium-Albuterol Solution inhaled by nebulizer four times a day related to shortness of breath. R38's care plan dated 9/3/21, failed to identify R38's need for assistance with administration of medications by nebulizer. On 10/6/21, at 12:03 p.m. registered nurse (RN)-A was observed setting up liquid medication for administration by nebulizer for R38. RN-A applied the face mask to R38 and reminded her to leave the mask on while receiving the medication. RN-A turned the nebulizer machine on, then walked towards R38's bedroom door. RN-A noted R38 was attempting to remove the face mask. RN-A returned to R38, reapplied the mask, reminded R38 to leave the mask in place until RN-A returned to remove, then left R38's room. After RN-A left R38's room, another surveyor observed R38 while the nebulizer was running. R38 did not make further attempts to remove the mask. On 10/6/21, at 12:15 p.m. nursing assistant (NA)-G was observed entering R38's room. NA-G turned off the nebulizer machine and removed the mask. On 10/6/21, at 1:49 p.m. RN-A confirmed she did not remove the mask or turn off the nebulizer	F 554	All residents who have inhaled medications will be assessed by DON/Nurse Managers upon admission, readmission and with new orders. If they do, a Medication Self-Administration assessment will be completed. If the residents are able to self-administer medications, a provider order will be obtained, and a care plan put into place. Self Administration will be monitored by DON/Nurse Manager quarterly and as needed. Self-administration will be audited by DON/designee upon admission and readmission via the Admission Audit form and as self-administration desire arises. Licensed nurses will be educated on the medication self-administration policy and process. Weekly monitoring of nurse/TMA medication administration passes on various shifts. Weekly medication self-administration audits will be conducted for four weeks, then monthly for one month. Audit results to be reviewed at monthly QAPI to evaluate the effectiveness of resident determination adherence and the need for audit continuation. DON/Designee is responsible for ensuring compliance.	

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F 554	Continued From page 7 machine, rather, she directed unlicensed staff, NA-G, to complete the task. RN-A stated self-administration of a nebulizer involved the resident placing the solution in the medication cup, applying the mask, and turning on the machine. RN-A did not consider leaving a severely cognitively impaired resident alone while receiving nebulized medication to be self-administration of medication. RN-A indicated she usually set up R38's nebulizer then left her unattended. "She is really good about keeping it on." RN-A stated she would check on R38 frequently while receiving the nebulizer. RN-A confirmed she did not perform frequent checks on R38 during this observation, and had NA-G check on R38 to remove the mask after 10 minutes of nebulizing. RN-A stated self-administration of medication required a doctor's order. RN-A confirmed R38 did not have an order to self-administer medications. On 10/7/21, at 1:53 p.m. NA-G confirmed she had removed the nebulizer mask and turned off the machine and had not been trained in this process. On 10/7/21, at 4:13 p.m. director of nursing (DON) indicated administration of nebulized medication included placing the solution in the medication cup, applying the mask, turning on the machine and staying with the resident until the medication was fully administered. Removing the mask and turning off the machine were also part of the administration process. DON expected medication administration was completed by a licensed nurse or those who were trained to administer medications. DON indicated self-administration of medications, including nebulized medication, required an assessment of	F 554	Corrective Date of Compliance: 11/12/2021	

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F 554	Continued From page 8 the resident's ability to safely self-administer medications and a doctor's order. DON confirmed, R38 had not been assessed to safely self-administer medications, nor did R38 have a doctor's order to self-administer medications. DON stated based on R38's cognitive status, she would not be appropriate for self-administration of medications. Facility policy, Self-Medication Assessment, revision date 1/2/19, noted residents shall have an assessment completed by a licensed nurse.	F 554		
F 565 SS=C	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the	F 565		11/12/21

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F 565	Continued From page 9 facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure residents were allowed to conduct periodic resident council meetings. This had the potential to affect all 67 residents residing in the facility. Findings include: A request of the last three resident council meeting minutes revealed one resident council meeting occurred on 7/22/21. The facility was unable to provide any further meeting notes. During an interview on 10/7/21, at 8:47 a.m. the activity director (AD) stated activities focused on one to one activities for the residents. The AD stated there was no discussion of grievances or rights while doing one to one activities with residents. The AD stated since she was hired in June there was only one resident council meeting on 7/22/21. The AD stated resident council meetings should be held monthly. Due to COVID they did not have resident council, they were in lock down for the year except July when they had a resident council meeting. They were unable to find any other resident council meeting minutes	F 565	Resident council meeting was held 10/21/2021 and the 3rd Thursday going forward. All residents have the potential to be affected. Monthly resident council meting are offered via the activity calendar which is placed in each resident's room monthly. Verbal invitation is made by activities staff/designee the day of Resident Council. In the event the facility is in outbreak status, accommodations will be made to ensure Resident Council is held. Accommodations can include video technology or holding multiple session in the hallway with social distancing. NHA, Social Services Director, and Activity Director educated on the Resident Council policy. Monthly audits will be completed for two months to validate the meetings are offered. Audit results to be reviewed at monthly QAPI to evaluate the effectiveness of resident determination adherence and the	

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F 565	Continued From page 10 for the year. During an interview on 10/8/21, at 10:14 a.m. the administrator stated ideally resident council would happen monthly. The administrator stated they were unable to locate any further resident council meeting minutes for the year. The facility's Resident Council policy, dated 2/26/20, indicated the facility would provide residents with the opportunity to air any grievances that they may have and to give suggestion on what they would like. Along with any changes they think should be made.	F 565	need for audit continuation. NHA/Designee is responsible for ensuring compliance. Corrective Date of Compliance: 11/12/2021	
F 610 SS=E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 610	R15 No adverse effects due to deficient	11/12/21

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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) COMPLETION DATE
F 610	Continued From page 11 facility failed to thoroughly investigate an allegation of abuse for 1 of 1 residents (R15) who alleged physical abuse by a staff member and 2 of 2 residents (R2 and R16) reviewed for resident to resident abuse. Findings include: R15's significant change Minimum Data Set (MDS), dated 9/25/21, indicated R15's hearing and vision were adequate and R15 was usually able to make himself understood. R15 required physical assistance from staff for bed mobility, transfers and toilet use. R15's diagnoses included aphasia (a communication disorder that impairs a person's ability to process language but does not affect intelligence). The facility's investigation file indicated on 8/9/21, the facility filed a report of alleged abuse with the State Agency (SA). The report resulted from an allegation made by R15 towards nursing assistant (NA)-F, who was no longer employed with the facility. Documents indicated on 8/9/21 at 5:05 p.m. the Administrator interviewed the Therapy Director about a concern form that she had filled out. This form indicated R15 alleged that NA-F kicked him in the back. Facility investigation and interviews completed and submitted to the SA on 8/9/21, included interviews with staff who witnessed the incident, however, the investigation failed to include interviews from other residents who also received care provided by NA-F. On 10/7/21, at 4:18 p.m. director of nursing (DON) stated a complete investigation for allegations of abuse, included interviews with	F 610	practice, and named staff member is no longer employee R2 No adverse effects due to deficient practice. R16 No adverse effects due to deficient practice. All residents have the potential to be affected. NHA, DON, Nurse Managers, and Social Services Director will be educated on the abuse policy. Weekly audits of reportable items will be conducted for two months. To ensure reportable items that require interview of potentially affected residents, the reporting agent will complete a comprehensive Verification of Investigation form. The VIO form includes key steps taken during investigation to ensure a thorough and comprehensive investigation, including but not limited to resident and staff interviewed, contributing factors, immediate actions taken to ensure safety. Audit results to be reviewed at monthly QAPI to evaluate the effectiveness of resident determination adherence and the need for audit continuation. NHA/Designee is responsible for ensuring compliance. Corrective Date of Compliance: 11/12/2021	

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F 610	Continued From page 12	F 610		

residents who also received care from NA-F. DON confirmed, the investigation into R15's allegations was not completed because it did not include interviews with other residents. DON indicated it was important to interview other residents who received care from NA-F to determine if there was a pattern of abuse and to ensure other residents felt safe when cared for by NA-F.

R2's quarterly Minimum Data Set (MDS), dated 7/1/21, indicated R2 did not have deficits in vision, hearing, or speech, and was understood and able to understand others. R2 had no cognitive impairment.

R2's face sheet, printed 10/8/21, indicated R2's diagnoses included encephalopathy (a disease of the brain that alters brain function or structure), dementia, and depression.

R2's care plan, revised 9/29/21, indicated R2 had been verbally threatening with others, and directed staff to move R2 to a quiet area, allow her to express her feelings, and ensure the safety of self and others.

R16's quarterly MDS, dated 8/5/21, indicated R16 had severe cognitive impairment. R16 did not have vision, hearing or speech deficits, and was usually understood and usually able to understand others.

R16's face sheet printed 10/8/21, indicated R16's diagnoses included dementia with behavioral disturbance, and adjustment disorder with anxiety.

R16's care plan, revised 8/12/21, indicated R16

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had behavior symptoms of being physically and verbally aggressive with others. Additionally, the care plan directed staff to intervene before agitation escalates, guide R16 away from source of distress, and calmly engage R16 in conversation. R16's care plan further indicated R16 had hit another resident on 6/7/21, and 7/7/21.

On 10/4/21, at 6:14 p.m. R2 stated "about two weeks ago, a resident hit me, and I hit them back". R2 further stated, "if someone hits me, I will hit them back".

An allegation of abuse regarding a resident-to-resident physical altercation between R2 and R16 was reported to Minnesota Department of Health (MDH) on 9/22/21, at 2:08 p.m. and the subsequent investigation report was submitted to MDH on 9/29/21, at 1:20 p.m.

The facility's investigation documentation for the 9/22/21 allegation, included an Investigation Summary Report dated 9/29/21, which indicated podiatry staff reported R16 hit R2 to nursing assistant (NA)-H at approximately 1:07 p.m. on 9/22/21. Video footage showed NA-H was in process of escorting R16 to another location when R2 hit R16 on 9/22/21 at 1:15 p.m. Additionally, the facility investigation documentation included an undated, typed statement signed by RN-A stating she did not notice any interaction between R2 and R16 leading up to the incident while podiatry was on site. The facility's documentation did not show evidence podiatry employee(s) that reportedly witnessed R16 hit R2 was interviewed. Also, there was no indication the facility interviewed the residents involved in the incident.

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F 610	Continued From page 14 On 10/8/21, at 10:08 a.m. director of nursing (DON) stated R2 had not retaliated in the past. R2 was "feisty, but not usually physical with other residents". The DON confirmed the residents and the podiatry staff were not interviewed as a part of the investigation. The facility Vulnerable Adult Abuse and Neglect Prevention policy revised 11/17/20, indicated "upon receiving a complaint of alleged maltreatment, the Administrator must be notified immediately, and the DON or assigned designee, will coordinate an investigation, which will include completion of witness statements" and "all parties involved including two of the following - staff, residents or visitors, who were potentially involved, or observed the alleged incident are to be interviewed by the DON, Director of Social Services, or their designees".	F 610		
F 678 SS=D	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 5 residents (R53) reviewed for Advance Directives, had their current health care wishes identified clearly in the medical record. Findings include:	F 678	R53 POLST was corrected on 10/8/2021 All residents have the potential to be affected. Resident□s POLST will be reviewed for accuracy and completeness. All POLSTs have been reviewed for accuracy.	11/12/21

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F 678	Continued From page 15 R53's admission Minimum Data Set (MDS) assessment, dated 9/23/21, indicated severe cognitive impairment, and required staff assistance with all activities of daily living (ADLs). R53's order summary report, printed 10/8/21, indicated R53 was admitted to the facility on 9/16/21, and had diagnoses of Alzheimer's disease, severe protein-calorie malnutrition, depression, and anxiety disorder. R53's Provider Orders for Life-Sustaining Treatment (POLST), signed by responsible party 9/16/21, indicated DNR (do not resuscitate), comfort-focused treatment to allow a natural death, no artificial nutrition by tube, and oral antibiotics only (no IV/IM). The POLST was signed by family member (FM)-A on 9/16/21, however, had not been signed by the health care professional who prepared the document. Also, there was no DNR orders found in R53's chart. R53's care plan last revised 9/29/21, indicated the following for advance directives: See current signed advance directive and/or POLST in resident's record. On 10/8/21, at 10:31 a.m. director of nursing (DON) verified the POLST indicated DNR, comfort-focused treatment, no artificial nutrition by tube, and oral antibiotics only. DON stated, "I don't see a provider signature or the health care professional who prepared the document's signature". DON confirmed the POLST was not a valid DNR order, she had been unaware of the error, and she would correct it immediately. The facility's policy, Advanced Directives, revised	F 678	Licensed nurses/TMA will be educated on the Advance Directives policy. Weekly audits will be completed of new admission□'s POLST to validate accuracy and completeness for two months. POLSTs will be reviewed upon admission, readmission, hospital return and with physician visits. This will be documented on the Admission Audit form. Residents that have appointments scheduled will be reviewed for POLST changes during morning meeting. Audit results to be reviewed at monthly QAPI to evaluate the effectiveness of resident determination adherence and the need for audit continuation. DON/Designee is responsible for ensuring compliance. Corrective Date of Compliance: 11/12/2021	

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F 678	Continued From page 16 5/4/21, directed "Residents without an advanced directive or DNR order, full CPR is performed unless clinically contraindicated". The policy further indicated, "If a resident becomes unresponsive, either witnessed or unwitnessed, the resident's Advanced Directives/POLST will be followed".	F 678		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and	F 755		11/12/21

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F 755	Continued From page 17 §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure the emergency medication kit (E-Kit) was properly secured in 1 of 2 medication rooms reviewed for medication storage. This has the potential to effect residents whom resided on the north wing. Findings include: On 10/8/21, at 9:34 a.m. during inspection of the north medication room with registered nurse (RN)-C the E-Kit was noted to not be secured with a color-coded zip tie. RN-C confirmed the E-kit was not secured with a color-coded zip tie. Review of Talahi Care Center Fridge E-Box, West Contents identified it had the contents of Lantus (used for diabetes) pen solostar 3 ml, 1 pen; Aspart (Insulin for diabetes) 3 ml, 1 pen; Novolin (Insulin for diabetes) R 10mL, 1 vial; Novolin (Insulin for diabetic) NPH 10mL, 1 vial; and Ativan (Lorazapam)(used for anxiety) 2 mg/ml, 2 injectable. On 10/8/21, at 9:37 a.m. RN-C stated she was not aware of the process for removal of medications from the E-Kit but did not think it included securing the box with a color-coded zip tie, "otherwise I think there would be one already on there." RN-C confirmed the E-Kit was delivered from pharmacy with a colored zip tie in place. The zip tie was removed when someone accessed the E-Kit. RN-C stated she was not sure how to determine who removed the original zip tie or for what reason.	F 755	E-kit emergency medication was secured on 10/8/2021. All residents have the potential to be affected. Licensed nurses will be educated on the process for securing of controlled medications in the E-kit. Weekly audits will be completed of the E-kits to validate medications are secured for two months. Audit results to be reviewed at monthly QAPI to evaluate the effectiveness of resident determination adherence and the need for audit continuation. DON/Designee is responsible for ensuring compliance. Corrective Date of Compliance: 11/12/2021	

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F 755	Continued From page 18 Retrospective Item Withdrawal Instructions, undated were adhered to the top of the E-Kit and included directions for removing medications, replacing the security seal(s) and returning the kit to the designated E-kit area. On 10/8/21, at 1:40 p.m. director of nursing (DON) stated there was a tracking book for the E-Kit. She expected the number on the zip tie removed was written in the book as well as the number on the different colored zip tie that was used to secure the E-Kit after it was opened, and a medication was removed. DON expected the E-Kit was checked each shift, by licensed nurses, to ensure it was secured.	F 755		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of	F 761		11/12/21

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F 761	Continued From page 19 the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure time sensitive medications were discarded after the beyond-use date had expired for 1 of 1 resident (R48) whom had eye drops in 1 of 2 medication carts reviewed for medication storage. Findings include: R48's face sheet, dated 10/8/21, included diagnoses of dementia and glaucoma in both eyes. R48's medication administration record (MAR) indicated R48 received eye drops, Pred Forte 1% (prednisolone acetate), one drop into both eyes two times a day for glaucoma. On 10/7/21, at 1:31 p.m. licensed practical nurse (LPN)-C was observed during a medication pass. R48's Pred Forte 1% eye drops had an opened date of 8/7/21. LPN-C confirmed R48 did not have another bottle of Pred Forte 1% in the medication cart and this bottle was currently in use. LPN-C was not aware of the after opened expiration date for this medication, but stated the medication was probably beyond that date and should have been discarded. On 10/8/21, at 9:57 a.m. pharmacy consultant (PC)-A stated Pred Forte eye drops needed to be	F 761	R48 eye drops which were expired were removed on 10/7/2021. All residents have the potential to be affected. DON/Nurse Managers completed an audit of the medication carts to validate no other expired items noted on 11/5/2021 Licensed nurses will be educated on the need to check the expiration dates of all medications. Weekly audits will be completed of medication carts for expired medications for two months. Audit results to be reviewed at monthly QAPI to evaluate the effectiveness of resident determination adherence and the need for audit continuation. DON/Designee is responsible for ensuring compliance. Corrective Date of Compliance: 11/12/2021	

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F 761	Continued From page 20 used within 28 days of the open date. The risk of using this medication beyond 28 days after the open date was increased risk for infection. On 10/8/21, at 1:40 p.m. director of nursing (DON) stated eye drops should be dated when opened. She expected nurses to call the pharmacy if they were not aware of how long eye drops can be used after they are opened. Facility policy regarding dating and use of eye drops was requested but not received.	F 761		
F 881 SS=E	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to establish an antibiotic stewardship program that included consistent implementation of protocols for appropriate antibiotic use for 4 of 5 residents (R160, R26, R158, R50) reviewed for antibiotic use. Findings include: During the recertification survey, the facility's antibiotic tracking tool for September and October 2021, were reviewed. The following was	F 881	R160, R26, and R50 were noted to have no adverse effects to the deficient practice. R158 had a planned discharged from the facility on 10/12/2021. R160 discharged from the facility on 10/12/2021. Residents with active infections have the potential to be affected. All residents with active infections have the potential to be affected.	11/12/21

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F 881	Continued From page 21 identified: R160 was prescribed Doxycycline (an antibiotic) from 9/28/21 to 10/5/21, for "lower respiratory tract" infection. The tracking tool further indicated "Criteria Met" as "yes", a "CXR" (chest x-ray) was completed on 9/28/21, and the column "Symptom(s)" was blank. The "Loeb's Minimum Criteria for Initiating Antibiotic Therapy" (LOEBS) [a professionally recognized set of criteria] to determine the presence of infection and guide appropriate antibiotic use, indicated with new infiltrate on CXR consistent with pneumonia, at least one of the following criteria was necessary for starting antibiotic therapy: 1) productive cough, 2) respiratory rate greater than (>) 25 breaths/minute, and/or 3) temperature >100 degrees Fahrenheit (F) or 2.4 degrees F above baseline. However, the facility failed to list any criteria with the CXR to determine the presence of infection. R26 was prescribed Doxycycline from 9/29/21 to 10/6/21, for "lower respiratory tract" infection. The tracking tool indicated "Criteria Met" as "Yes". However, the columns "Symptom(s)" and "Diagnostic Performed" were blank. This potential infection was treated with antibiotics; however, there was no evidence any recognized set of criteria (i.e. LOEBS) was used to determine the presence of infection before the antibiotic was initiated. R158 was prescribed Ceftriaxone (an antibiotic) and Ampicillin (an antibiotic) from 10/2/21 to 10/7/21, for "UTI" infection. The tracking tool indicated "Criteria Met" as "Yes" for each antibiotic. However, the columns "Symptom(s)" and "Diagnostic Performed" were blank for both	F 881	All residents who have received antibiotics since 10/1/2021 have been added to the Antibiotic log with criteria for usage addressed. Provider notification was completed and documented. DON and Nurse Managers educated on the Antibiotic Stewardship policy. Infection Preventionist hired with a start date of 11/8/2021. Weekly audits will be completed of the infection log for accuracy and completeness for two months. Audit results to be reviewed at monthly QAPI to evaluate the effectiveness of resident determination adherence and the need for audit continuation. DON/Designee is responsible for ensuring compliance. Corrective Date of Compliance: 11/12/2021	

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F 881	Continued From page 22	F 881		

antibiotics. This potential infection was treated with two different antibiotics; however, there was no evidence any recognized set of criteria was used to determine the presence of infection before the antibiotics were initiated.

R50 was prescribed Cefpodoxime (an antibiotic) from 10/4/21 to 10/22/21, for "UTI" infection. The tracking tool indicated "Criteria Met" as "Yes". However, the columns "Symptom(s)" and "Diagnostic Performed" were blank. This potential infection was treated with antibiotics; however, there was no evidence any recognized set of criteria was used to determine the presence of infection before the antibiotic was initiated.

On 10/8/21, at 10:08 a.m. the director of nursing (DON) stated the facility used LOEBS to determine if criteria were met before initiating an antibiotic. During a follow-up interview on 10/8/21, at 2:51 p.m. DON confirmed information on the tracking tool was missing for R160, R26, R158, and R50, and because no symptoms were indicated, there was no evidence any recognized set of criteria was used to determine the presence of infection before the antibiotic was initiated. Additionally, DON stated, "I missed putting in the symptoms; I know it should be in there."

Facility's Antibiotic Stewardship policy revised 12/20/19, indicated the purpose of the antibiotic stewardship program was "to promote appropriate use of antibiotics for quality of care, successful resident outcomes and reduction of potential adverse consequences related to antibiotic use". Additionally, the policy indicated an antibiotic would be ordered based upon McGeers (LOEBS) criteria, and the Infection

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F 881	Continued From page 23 Preventionist would track antibiotic use and monitor adherence to evidence-based criteria.	F 881		
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 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;	F 886		11/12/21

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F 886	Continued From page 24 §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. §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 staff for COVID-19 according to county transmission rate, and outbreak status as directed by the Center for Disease Control (CDC). The facility was in COVID-19 outbreak status since 9/17/21 which resulted in four staff (NA-D, NA-E, PT-A, DA-A) testing positive for COVID-19. Further, the facility failed to restrict 1 of 1 staff (DA-A) to return to work whom had COVID-19 symptoms 3 days earlier, pending the results of COVID-19 testing. This practice	F 886	Immediate Action: Reconcile all staff working since the start of the outbreak on 10/6/2021 to validate all staff are testing every 3-5 days and 5-7 days with at least 2-3 days in between testing related to outbreak testing. System Correction: Routine Testing (not in an outbreak): Daily review of staff working to validate they have received testing per community positivity rates for routine testing of	

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F 886	Continued From page 25 resulted in an immediate jeopardy (IJ) situation which had the likelihood to cause serious illness or death for all 67 residents residing in the facility. The immediate jeopardy began on 9/17/21, when the facility was notified a staff member tested positive for COVID-19. The administrator and director of nursing (DON) were notified of the immediate jeopardy on 10/7/21, at 5:57 p.m. The immediate jeopardy was removed on 10/12/21, at 10:30 a.m. but noncompliance remained at the lower scope and severity level of F, which indicated widespread scope, and no actual harm with potential for more than minimal harm that was not immediate jeopardy. Findings include: During entrance conference on 10/4/21, at 11:48 a.m. administrator and DON (Director of Nursing) stated she was the Infection Preventionist, the facility census was 67 residents, and the facility was currently testing staff twice a week because of high community transmission rate. Additionally, the DON stated there had been no active or suspected COVID-19 cases in the building for the last two weeks. The CDC Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes updated 9/10/21, indicated a single new case of SARS-CoV-2 infection in any health care personnel (HCP) or a facility-onset SARS-CoV-2 infection in a resident should be evaluated as a potential outbreak, and the facility should perform testing for all residents and HCP on the affected unit(s), regardless of vaccination status, immediately (but not earlier than 2 days after the exposure, if known) and, if	F 886	unvaccinated staff. IDT will review in the morning meeting on business days and the nurse manager on duty will be responsible to review on weekends and holidays. Outbreak Testing: Daily review of all staff working, regardless of vaccination status, to validate they have completed testing every 3-5 days and 5-7 days with at least 2-3 days in between testing. IDT will review in the morning meeting on business days and the nurse manager on duty will be responsible to review on weekends and holidays. Residents will be tested every 3-7 days during an outbreak regardless of vaccination status. Log created to show the community transmission rates, testing schedules, staff vaccination record, and testing records. Regional Director of Clinical Services (Larisa Klein, RN) will provide oversight of the Infection Prevention Program for Edenbrook of Saint Cloud in conjunction with the Director of Nursing/Infection Preventionist (Krista Donnabauer, RN) for the next 2 months and then will reevaluate the effectiveness of the oversite and training to determine if additional oversight is needed. Initial oversight will include daily in person or phone call discussions Monday through Friday and as needed on the weekends x 1 month, then three times per week x 1 month. This additional layer of oversight will be reduced in frequency if/when an Infection Preventionist is hired at the facility. Policy Update: an addendum to the COVID-19 Testing Plan Policy has been	

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F 886	Continued From page 26 negative, again 5-7 days later. If no additional cases are identified during the broad-based testing, no further testing is indicated after 14 days. However, if additional cases are identified, testing should continue every 3-7 days until there are no new cases for 14 days. The document further indicated unvaccinated HCP should continue routine testing based on the CDC Reports of COVID-19 Community Transmission Levels, and in nursing homes located in counties with substantial to high community transmission, unvaccinated HCP should have viral testing twice a week. Additionally, anyone with even mild symptoms of COVID-19, regardless of vaccination status, should receive a viral test as soon as possible; and symptomatic HCP, regardless of vaccination status, should be restricted from work pending evaluation for SARS-CoV-2 infection. According to the CDC Reports of COVID-19 Community Transmission Levels per CDC Data Tracker for Minnesota, Stearns County was at a "High" Level of Community Transmission between 8/11/21 to 10/8/21. The facility provided an untitled document, printed 10/4/21, with the handwritten text "83% COVID Vax" (vaccination) on the top of the document. The document was a list of resident names and their COVID-19 vaccination record for each resident. The facility provided an untitled document, dated as of 9/20/21, with the hand written text "49% COVID Vax" at the top of the document. The document identified a list of staff names, cell phone number, job title, and COVID-19 vaccination status.	F 886	made. Infection Preventionist was hired with a start date of 11/8/2021. Education: Education for Infection Prevention was initiated immediately. OnShift message was sent to all staff on 10/7/2021 to notify them of the education which is required to be completed prior to the start of their next shift. All staff educated that during a COVID outbreak, testing every 3-5 days and 5-7 days with at least 2-3 days in between testing is required if they work during that week, regardless of vaccination status. All staff educated that during routine testing (non-outbreak), unvaccinated staff will be tested per the community transmission rates during each week they work. All staff educated that if they have any COVID-19 symptoms, they are to be tested immediately and do not return to work per CDC guidelines. Charge Nurses and Nurse Managers educated that on testing days, when staff are testing at the start of their shift, review of the test results needs to take place within 30 minutes of the test to validate the results. If a staff member is positive, they are to immediately leave the building and return home. If a staff member states they have symptoms, they are to be immediately tested at the door and not leave the testing area until the test has been completed and follow the CDC guidelines for ability to work. Director of Nursing/Infection Preventionist educated on the COVID-19 Testing Plan Policy Addendum.	

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F 886	Continued From page 27 The DON provided in the morning on 10/5/21, several stacks of rubber-banded, untitled forms. She identified these were the facility testing forms. Each untitled form indicated the staff name, gender, date of birth, home address, contact phone number, symptoms, pregnancy status, date, time, and COVID testing results. The DON also provided in the morning on 10/5/21 an untitled, undated document with a list of staff names. The DON stated the document was, a listing of "COVID positive staff for 2021". The list contained 13 staff names and the date each tested positive for COVID-19. The positive staff ranged from January to August 2021, with the last staff identified being positive was on 8/23/21. The DON identified on 10/6/21, at 1:35 p.m. the stacks of rubber-banded documents was their tracking method for COVID-19 testing of staff. Additionally, DON reported she did not have a system in place to ensure unvaccinated staff were completing COVID testing as identified by county transmission rate or that all staff were tested as required when the facility was in outbreak status. The DON was unable to determine which staff completed testing or if they tested at all. The facility's List of COVID Positive Staff for 2021 indicated the previously identified COVID-19 infection had been 8/23/21, 23 days before NA-D's positive result on 9/17/21. Review of the rubber banded documents and COVID testing (POC testing results) identified the following:	F 886	All staff who are available have been educated by 10/8/2021. Any staff unavailable will be educated prior to the start of their next shift until all staff have been educated. Audits: Audits completed weekly to validate all required tests have been completed for two months. Audit results to be reviewed at monthly QAPI to evaluate the effectiveness of resident determination adherence and the need for audit continuation. Responsible Party: DON/Infection Preventionist/Designee Corrective Date of Compliance: 11/12/2021	

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NA-D
NA-D's POC Testing Result Report identified she was COVID positive on 9/16/21.

On 10/7/21, at 9:21 a.m. DON stated NA-D received a polymers chain reaction (PCR) test on 9/15/21, NA-D worked on 9/16/21, and the facility became aware on 9/17/21 NA-D was positive. DON further stated NA-D was asymptomatic and worked on 9/15/21, 9/16/21, and was removed from the schedule on 9/17/21 until 9/30/21. The facility's vaccination document, identified NA-D was fully vaccinated. The DON stated, because NA-D was positive the facility started testing residents and staff twice a week for outbreak testing starting on 9/17/21.

NA-E
DON stated on 10/7/21, at 9:21 a.m. NA-E received a COVID-19 test outside the facility on 9/22/21, 6 days after NA-D tested positive. DON stated, NA-E was asymptomatic when she last worked at the facility 9/16/21 and had not worked since, and then became symptomatic and tested positive on 9/22/21. DON further stated NA-E was removed from the schedule until 10/6/21. The 9/20/21 staff vaccination form, identified NA-E was fully vaccinated. The POC Test Result form, printed on 10/7/21 indicated that NA-E was last tested on 9/7/21, even though she was not required to be tested because she was fully vaccinated per CDC recommendations.

PT-A
PT-A's POC Test Results report, printed 10/7/21, indicated PT-A tested positive for COVID-19 on 10/1/21, and tested negative for COVID-19 on 9/29/21. The facility Labor Details Report printed 10/7/21 indicated PT-A worked on 9/18, 9/23 and

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9/24/21. The facility provided no evidence PT-A was tested twice a week between 9/17/21 and 9/28/21 while the facility was in outbreak status.

During interview on 10/7/21, at 9:21 a.m. the DON stated PT-A became symptomatic and did not work but was tested on 10/1/21. PT-A was removed from the schedule after testing positive. Her return date was undetermined. The DON stated at 5:12 p.m. that PT-A had not been tested for COVID-19 between 9/17/21 and 9/28/21 and acknowledged PT-A should not have worked on 9/18, 9/23, and 9/24/21 without first being tested, as the facility was in outbreak status.

DA-A:
The DON stated on 10/7/21, at 9:21 a.m. that dietary aide (DA)-A arrived at work at 7:00 a.m. on 10/3/21 and was sent home at 7:15 a.m. after notifying her supervisor that she had a headache. DA-A was not tested for COVID-19 even though DA-A had COVID symptoms. DA-A returned to the facility on 10/6/21, at 2:00 p.m. and did not have any COVID symptoms. On 10/6/21, at 3:30 p.m. the DON identified DA-A has not completed any testing for the day, and had DA-A complete a test. DA-A tested positive for COVID-19. DA-A had worked for 90 minutes on 10/6/21 before she was tested.

Review of a facility provided form, untitled, dated 10/6/21, indicated DA-A's name, gender, date of birth, home address, contact phone number, pregnancy status, symptoms "none", dated 10/6/21 at 3:30 p.m. results "positive", and the DON's initials were written on the form.

The facility provided document, untitled, dated as of 9/20/21, indicated DA-A was not vaccinated for

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F 886	Continued From page 30	F 886		

COVID-19.

Review of DA-A's POC Test Results report, printed 10/7/21, indicated DA-A tested negative for COVID-19 on 9/24/21, 9/14/21, 9/8/21, 9/4/21, 9/3/21, 9/2/21, 8/30/21, 8/27/21, and 8/26/21. DA-A did not test biweekly as identified by the county transmission rate for routine testing. DA-A only tested weekly during this time. In addition, the facility provided no evidence DA-A completed outbreak testing between 9/17/21 to 9/24/21, and 9/25/21 to 10/6/21. Further, there was no indication DA-A completed testing before she worked with residents and other staff.

Review of Talahi Nursing and Rehab Center Schedule, dated 9/1-9/30/21, and 10/1-10/7/21, indicated DA-A consistently worked 4-5 days a week from 9/2-10/6/21.

After review of facility provided testing paperwork, there was no indication the facility implemented outbreak status testing guidelines as identified by the CDC. There was no indication the facility had completed staff testing twice a week, testing immediately (but not earlier than 2 days after the exposure, if known) and, if negative, again 5-7 days later, until there were 14 days where no staff have tested positive for COVID.

On 10/7/21, at 9:21 a.m. the DON stated PCR tests were done on Tuesdays, POC tests were done on Fridays, and outbreak testing lasted until the facility had 14 days without any new positive cases. In addition, DON stated if staff missed scheduled testing dates, they were expected to complete a POC test the first date they returned to work before going on the floor stating, "I encourage everyone to get tested". The DON

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confirmed a tracking system was not in place to monitor for staff COVID-19 testing compliance.

During interview on 10/7/21, at 5:12 p.m. the DON confirmed DA-A was unvaccinated and removed from the schedule after testing positive for COVID-19 with an undetermined return date. The DON further confirmed DA-A had not completed routing testing twice a week between 9/5/21 and 9/16/21. In addition, the DON stated DA-A was not tested for COVID-19 between 9/24/21 and 10/5/21 while the facility was in outbreak status. The DON acknowledged DA-A should not have worked 10/1/21 and 10/2/21.

The facility's COVID-19 Testing Plan policy revised 9/13/21, indicated the facility would test all unvaccinated staff at the frequency prescribed by the CDC based on community transmission level. The policy further indicated outbreak means there is a new COVID-19 infection in any staff, or any nursing home-onset COVID-19 resident infection. In response to an outbreak, all residents and staff would be tested regardless of vaccination status and serial testing would be completed every 3-7 days until there were no new positive cases for 14 days. In addition, the policy indicated staff with COVID-19 signs or symptoms would be tested regardless of vaccination status, and the staff member would not report to work while waiting for test results.

The IJ was removed on 10/12/21, at 10:30 a.m. when it was verified through interview and document review the facility policies were reviewed and an addendum dated 10/8/21, was added to reflect protocol for outbreak testing, routine testing of unvaccinated staff, and staff that do not comply with testing requirements. The

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F 886	Continued From page 32 facility developed a testing plan which included daily review of staff schedules to validate testing compliance. Education to all staff was provided on updated COVID-19 testing protocols prior to scheduled shifts. Regional Director of Clinical Services provided the DON with additional education, and will continue to provide oversight, education, and support. Completion of testing and training will be tracked, analyzed, and acted upon to ensure compliance.	F 886		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 3, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: VHT611

Dear Administrator:

The above facility was surveyed on October 4, 2021 through October 12, 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 only a suggestion 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. 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.

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:

Judy Loecken, 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: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

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
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Program Assurance Unit
Health Regulation Division
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cc: Licensing and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245438	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/05/2021**

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
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Talahi Nursing and Rehab Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENTS ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/05/2021

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.

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K 000	Continued From page 1 HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Talahi Nursing and Rehab Center is a 1-story building, plus a partial basement, and the facility was originally constructed in 1967 with additions in 1969, 1984, 1998, and 2005. The 2005 addition had its plan review completed in 2002. The facility was determined to be Type II(000) construction. The facility was surveyed as one building. The building is protected by a complete fire	K 000		

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K 000	Continued From page 2 sprinkler system. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a licensed capacity of 77 beds and had a census of 67 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a) are NOT MET as evidenced by:	K 000		
K 132 SS=D	Multiple Occupancies - Contiguous Non-Health CFR(s): NFPA 101 Multiple Occupancies - Contiguous Non-Health Care Occupancies Non-health care occupancies that are located immediately next to a Health Care Occupancy, but are primarily intended to provide outpatient services are permitted to be classified as Business or Ambulatory Health Care Occupancies, provided the facilities are separated by construction having not less than 2-hour fire resistance-rated construction, and are not intended to provide services simultaneously for four or more inpatients. Outpatient surgical departments must be classified as Ambulatory Health Care Occupancy regardless of the number of patients served. 18.1.3.4.1, 19.1.3.4.1 This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was revealed that 1 of 2 - two-hour fire separation was found not in compliance with NFPA 101 "The Life Safety Code" 2012 edition, sections 8.2.1.3 and 19.1.3.4. This deficient condition could have an	K 132	All residents have the potential to be affected. The 90-minute fire-rated door at the North Wing entry door in back of main dining room has been repaired on October 7,	11/12/21

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K 132	Continued From page 3 isolated impact on the residents within the facility. Findings include: On 10/05/2021, at 10:50 AM, during the facility tour, it was observed that the 90-minute fire-rated door located at the North wing entry near the back half of the main dining room did not fully close and latch into the door frame. This deficient condition was verified by a Maintenance Supervisor.	K 132	2021 Maintenance employees have been educated on completing door checks. Weekly audits will be conducted for four weeks, then monthly for one month. Audit results to be reviewed at monthly QAPI to evaluate the effectiveness of the fire rated doors and the need for audit continuation. Adm/Director of Environmental Services or designee is responsible for ensuring compliance. Corrective Date of Compliance: 11/12/2021	
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on staff interview and a review of the available documentation, the facility has failed to ensure that the annual 90-minute test/inspections of battery-operated emergency lights in accordance with the NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 7.9.3.1.1 (1). This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 10/05/2021, at 9:40 AM, during the review of all available battery-operated emergency lighting testing documentation and interview with the	K 291	All residents have the potential to be affected. The 90-minute annual test/inspection for the battery powered emergency lights was completed on 3/17/2021, a copy is now in our LSC binder. TELS system will be used for reminders and the information will be utilized to ensure compliance. Maintenance employees have been educated on completing the annual emergency lighting checks by the dates setup in the TELS system and documentation into the LSC book. Monthly audits will be conducted for four	11/12/21

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K 291	Continued From page 4 Maintenance Supervisor, it was observed that the facility could not provide information or documentation for the annual 90-minute test/inspection for the battery powered emergency lights. This deficient condition was verified by the Maintenance Supervisor.	K 291	months. Audit results to be reviewed at monthly QAPI to evaluate the effectiveness of remote annunciator of the generator and the need for audit continuation. Adm/Director of Environmental Services or designee is responsible for ensuring compliance. Corrective Date of Compliance: 11/12/2021	
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons)	K 321		11/12/21

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K 321	Continued From page 5 f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility has failed to provide proper protection for 1 of several hazardous areas located throughout the facility in accordance with NFPA 101 "The Life Safety Code" 2012 edition, section 19.3.2.1. This deficient condition could have an isolated impact on the residents within the facility. Findings include: On 10/05/2021, at 11:00 AM during the facility tour, observations revealed that the soiled utility room located near the North Wing nurses station has a door that has a 2 and 1/2 inch by 1-inch portion of the door broken off and is also missing the lathing tang hardware and will not positively close and latch into the door frame. This deficient condition was verified by the Maintenance Supervisor.	K 321	All residents have the potential to be affected. The North Wing nurses station door which was broken and missing lathing tan hardware and not positively closing and latching into the door frame has been corrected on 10/7/2021. TELS system will be used for reminders and the information will be utilized to ensure compliance. Maintenance employees have been educated on completing building audits, especially on door checks. Weekly audits will be conducted for four weeks, then monthly for two months. Audit results to be reviewed at monthly QAPI to evaluate the effectiveness of door compliance continuation. Adm/Director of Environmental Services or designee are responsible for ensuring compliance. Corrective Date of Compliance: 11/12/2021	
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small	K 324		11/12/21

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K 324	Continued From page 6 appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, it was determined that the facility has failed to ensure that the semi-annual inspections of the kitchen hood ventilation and fire suppression system protecting the cooking appliances have been completed in accordance with NFPA 101 "Life Safety Code" 2012 edition, section 9.2.3 and NFPA 96 (11) section 11.5, states that for moderate-volume cooking operations, the hood system and components shall be inspected and maintained semiannually by a properly trained, qualified, and certified company or person. This deficient condition could have an isolated impact on the residents within the facility.	K 324	All residents have the potential to be affected. The test/inspection documentation for both the semi-annual kitchen hood suppression systems inspections was completed on 3/17/2021 by Brothers Fire. The document is in the LSC binder. Brother's Fire will be used again this year for the second semi-annual inspection. TELS system will be used for reminders and the information will be utilized to ensure compliance. Maintenance employees have been educated on ensuring they receive the semi-annual kitchen hood suppression systems inspections and placing them in the LSC binder.	

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K 324	Continued From page 7 Findings Include: On 10/05/2021 at 9:45 a.m., during the review of all available documentation for the kitchen hood ventilation and fire suppression system inspection reports and interview with the Maintenance Supervisor, the facility did not provide complete test/inspection documentation for both of the semi-annual kitchen hood suppression system inspections. This deficient condition was verified by the Maintenance Supervisor.	K 324	Monthly audits will be conducted for six months. Audit results to be reviewed at monthly QAPI to evaluate the effectiveness of door compliance continuation. Adm/Director of Environmental Services or designee are responsible for ensuring compliance. Corrective Date of Compliance: 11/12/2021	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and maintain the fire alarm in accordance with NFPA 101 "Life Safety Code" 2012 edition, section 9.6.1.3, and NFPA 72 "National Fire Alarm and Signaling Code" 2010 edition, sections 14.5.3. and 14.6.2.4. This deficient condition could have a widespread impact on the residents within the facility.	K 345	All residents have the potential to be affected. The fire alarm tests and inspection documentation for the semi-annual inspection of all initiating devices has been completed by Brothers on 3/17/2021. Brothers Fire will be used again this year for a second semi annual test. TELS system will be used for reminders	11/12/21

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K 345	Continued From page 8 Findings include: On 10/05/2021, at 9:30 AM, during a review of all available fire alarm tests and inspection documentation and an interview with the Maintenance Supervisor, it was revealed that the facility could not provide any current documentation verifying that a semiannual inspection of all initiating devices had been completed. This deficient condition was verified by the Maintenance Supervisor.	K 345	and the information will be utilized to ensure compliance. Documentation from Brothers Fire and is in the LSC binder for the building. Maintenance employees have been educated on ensuring they receive the semi-annual inspection of the initiating devices and place them in the LSC binder. Monthly audits will be conducted for six months. Audit results to be reviewed at monthly QAPI to evaluate the effectiveness of door compliance continuation. Adm/Director of Environmental Services or designee are responsible for ensuring compliance. Corrective Date of Compliance: 11/12/2021	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for	K 353		11/12/21

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K 353	Continued From page 9 any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and a review of the available fire sprinkler test and inspection documentation, the automatic sprinkler system is not maintained in accordance with NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 9.7.1.1, and NFPA 25 the Standard for the Inspection, Testing, and Maintenance of Water Based Fire Protection Systems 2011 edition section 5.2.5 and 5.3.2.1. These deficient conditions could have a widespread impact on the residents within the facility. Findings include: 1. On 10/05/2021, at 9:10 AM, during the review of all available fire sprinkler test and inspection documentation and interview with the Maintenance Supervisor, it was revealed that the facility could not provide 3 of 4 quarterly flow tests and inspection documentation for the fire sprinkler system. 2. On 10/05/2021, at 12:04 PM, during the facility tour, observations revealed that the fire sprinkler riser located on the lower level Nature's Point unit has a gauge that appeared to be out of date for replacement or recalibrating. 3. On 10/05/2021, at 12:04 PM, during the facility tour, observations revealed that the fire sprinkler spare sprinkler headbox located on the lower level Nature's Point unit has three sprinkler heads that were not secured and protected from	K 353	All residents have the potential to be affected. The fire sprinkler test and inspection documentations of the quarterly flow tests has been completed on 3/17/2021 by Brothers fire report is in the LSC binder. The fire sprinkler riser unit had a gauge that was out of date for replacement or recalibration. It has been replaced or recalibrated on 11/2/2021 Sprinkler spare sprinkler headbox sprinkler heads have now been secured and protected from damage on 10/7/2021 Maintenance employees have been educated on ensuring they receive the fire sprinkler tests and inspections and place them in the LSC binder. Maintenance employees have been educated on ensuring they check the fire sprinkler riser unit and verify gages are not out of date or in need of recalibration. Maintenance employees have been educated on ensuring that sprinkler spare sprinkler head box sprinklers have been secured and protected from damage. Monthly audits will be conducted for four months, then yearly. Audit results to be reviewed at monthly QAPI to evaluate the effectiveness of maintenance of sprinkler system compliance continuation. Adm/Director of Environmental Services or designee are responsible for ensuring compliance.	

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K 353	Continued From page 10 damage. 4. On 10/05/2021, at 12:10 PM, during the facility tour, observations revealed that the fire sprinkler riser located on the lower level boiler room has a gauge that appeared to be out of date for replacement or recalibrating. 5. On 10/05/2021, at 12:10 PM, during the facility tour, observations revealed that the fire sprinkler spare sprinkler headbox located on the lower level Nature's Point unit had a sprinkler head that was not secured and protected from damage. These deficient conditions were verified by the Maintenance Supervisor.	K 353	Corrective Date of Compliance: 11/12/2021	
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain 1 of 5 smoke barrier	K 372	All residents have the potential to be affected.	11/12/21

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K 372	Continued From page 11 walls in accordance with the requirements of NFPA 101 "Life Safety Code" 2012 edition, sections 19.3.7.3 and 8.3. This deficient condition could have a patterned impact on the residents within the facility. Findings include: 1. On 10/05/2021 at 10:45 AM, observation revealed that the facility had used a non-fire-rated penetration sealant around a conduit that is passing through the smoke barrier wall above the ceiling tile over cross-corridor doors located the smoke barrier by the resident room 166. 2. On 10/05/2021 at 11:08 AM, observation revealed that there are multiple through penetrations that have not been sealed with fire-rated through penetration sealant in the smoke barrier wall above the ceiling tile over cross-corridor doors located the smoke barrier by the west tub room. These deficient conditions were verified by a Maintenance Supervisor.	K 372	The non-fire-rated penetration sealant used around a conduit that is passing through a smoke barrier wall above the ceiling tile over cross-corridor doors located by resident room 166 has been correct on 10/7/2021 The multiple through penetrations that are not sealed with fire-rated through penetration sealant in the smoke barrier wall above the ceiling tile over cross-corridor doors located by the west tub room have been correct on 10/7/2021 Maintenance employees have been educated on ensuring they utilize fire-rated penetration sealant around conduit passing though smoke barriers. Monthly audits will be conducted for four months. Audit results to be reviewed at monthly QAPI to evaluate the effectiveness of Smoke barrier compliance continuation. Adm/Director of Environmental Services or designee are responsible for ensuring compliance. Corrective Date of Compliance: 11/12/2021	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted	K 712		11/12/21

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	245438	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/05/2021**

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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K 712	Continued From page 12 between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.2 and 19.7.1.4. This deficient condition could have a widespread impact on the residents within the facility. Findings include: 1. On 10/05/2021, at 9:15 AM., during the review of all available fire drill documentation and interview with the Maintenance Supervisor, it was revealed that the facility did not conduct 1 of 4 fire drills for the day shift. 2. On 10/05/2021, at 9:15 AM., during the review of all available fire drill documentation and interview with the Maintenance Supervisor, it was revealed that the facility did not conduct 2 of 4 fire drills for the evening shift. 3. On 10/05/2021, at 9:15 AM., during the review of all available fire drill documentation and interview with the Maintenance Supervisor, it was revealed that the facility did not conduct 2 of 4 fire drills for the overnight shift. These deficient conditions were verified by the Maintenance Supervisor.	K 712	All residents have the potential to be affected. The Environmental Services Director will utilize the TELS system for ensuring fire drills are completed as required of one shift per quarter. Documentation from Fire Drill will be collected and will be printed and put into the LSC binder for the building. Maintenance employees have been educated on ensuring they conduct fire drills as required by LSC. Monthly audits will be conducted for six months to ensure compliance. Audit results to be reviewed at monthly QAPI to evaluate the effectiveness of fire drills compliance continuation. Adm/Director of Environmental Services or designee are responsible for ensuring compliance. Corrective date of completion 11/12/2021	
K 901 SS=F	Fundamentals - Building System Categories	K 901		11/12/21

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K 901	Continued From page 13 CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on staff interview and a review of all available documentation, the facility has failed to provide a complete and current facility Risk Assessment in accordance with the NFPA 99 "Health Care Facilities Code" 2012 edition section 4.1. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 10/05/2021, at 10:00 AM, during the documentation review and an interview with Maintenance Supervisor, it was revealed that the facility could not provide a completed utility risk assessment document at the time of the inspection. The utility risk assessment that was provided at the time of the inspection did not cover patient care equipment as detailed in NFPA 99 "Health Care Facilities Code" 2012 edition Chapter 10 - Electrical Equipment, and Chapter 11 - Gas Equipment.	K 901	All residents have the potential to be affected. The utility risk assessment documents have been completed on 11/5/2021. The Environmental Services Director will utilize the TELS system for ensuring the risk assessment tool is completed yearly and as needed. Documentation will be put into the LSC binder for the building. Maintenance employees have been educated on ensuring they utilize and update as necessary the utility risk assessment document and place in the LSC book. Monthly audits will be conducted for four months, and then each quarter for 4 quarters. Audit results to be reviewed at monthly QAPI to evaluate the effectiveness of risk assessment compliance continuation. Adm/Director of Environmental Services or designee are responsible for ensuring compliance.	

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K 901	Continued From page 14 This deficient condition was verified by the Maintenance Supervisor.	K 901	Corrective date of completion 11/12/2021	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on staff interview and a review of the available electrical outlet maintenance and testing documentation, that the electrical testing and maintenance was not maintained in accordance with NFPA 99 "Health Care Facilities Code" 2012 edition, section 6.3.4. This deficient condition could have a widespread impact on the residents within the facility.	K 914	The electrical outlet maintenance and testing documentation has been completed on 11/5/2021. The Environmental Services Director will utilize the TELS system for ensuring the electrical outlet maintenance and testing documentation is maintained. Documentation will be printed and put into	11/12/21

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K 914	Continued From page 15 Findings include: On 10/05/2021, at 9:50 AM, during the review of all available electrical outlet maintenance and testing documentation and an interview with the Maintenance Supervisor, the facility could not provide any current documentation for the completion of the annual inspection and testing of the electrical outlets within patient/resident care areas located throughout the facility. This deficient condition was verified by a Maintenance Supervisor.	K 914	the LSC binder for the building. Maintenance employees have been educated on ensuring they utilize TELS and ensure that the electrical outlet maintenance and testing documentation is completed and in the LSC binder. Monthly audits will be conducted for four months Audit results to be reviewed at monthly QAPI to evaluate the effectiveness of electrical outlet maintenance and testing compliance continuation. Adm/Director of Environmental Services or designee are responsible for ensuring compliance. Corrective date of completion 11/12/2021	
K 916 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to monitor the emergency generator in accordance with the NFPA 99 " Healthcare Facilities Code" 2012 edition, section 6.4.1.1.17. This deficient condition could have a widespread impact on the residents within the facility.	K 916	All residents have the potential to be affected. A remote annunciator for the generator has been ordered on 11/3/2021 from Allied Generator. Equipment will be installed by an electrician and Allied	11/12/21

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K 916	Continued From page 16 Findings include: On 10/05/2021, at 11:08 AM, during the facility tour, observations revealed that the facility did not have a remote annunciator panel installed for monitoring the operating status of the facility's emergency generator at any locations outside of the generating room or in any locations readily observed by operating personnel at a regular work station. This deficient condition was verified by the Maintenance Supervisor.	K 916	Generator will connect part once it arrives at facility. Charge nurses on duty, Manager One Duty, on-call RN or whomever is always assigned as “charge” will be educated on reading the remote annunciator panel for the generator. Weekly audits will be conducted for four weeks, then monthly for one month. Audit results to be reviewed at monthly QAPI to evaluate the effectiveness of remote annunciator of the generator and the need for audit continuation. Adm/Director of Environmental Services or designee is responsible for ensuring compliance. Corrective Date of Compliance: 11/12/2021	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a	K 920		11/12/21

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K 920	Continued From page 17 substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to monitor conditions affecting the facility's electrical system that was not in accordance with the NFPA 101 "Life Safety Code" 2012 edition, section 9.1.2, the NFPA 70 "National Electrical Code" 2011 edition, and the NFPA 99 " Healthcare Facilities Code" 2012 edition, section 10.2.4. This deficient condition could have an isolated impact on the residents within the facility. Findings include: On 10/05/2021, at 11:20 AM, during the facility tour, observations revealed that there is an extension cord being used in place of permanent wiring that has been strung up the wall and through the open space above the ceiling tiles and down to a call light marque information sign that is located in the Main Street corridor by the west wing nurses station. This deficient condition was verified by the Maintenance Supervisor.	K 920	All residents have the potential to be affected. One power cord has been removed and an electrical outlet was installed on 10/7. Maintenance employees have been educated on ensuring they utilize electrical outlets and no power cords to connect equipment. Monthly audits will be conducted for four months, then quarterly for 3 quarters. Audit results to be reviewed at monthly QAPI to evaluate the effectiveness of remote annunciator of the generator and the need for audit continuation. Adm/Director of Environmental Services or designee is responsible for ensuring compliance. Corrective Date of Compliance: 11/12/2021	
K 923 SS=E	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101	K 923		11/12/21

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K 923	Continued From page 18 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the	K 923	All residents have the potential to be	

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K 923	Continued From page 19 oxygen storage room was not identified in accordance with NFPA 101 "Life Safety Code" 2012 edition, sections 8.7.1.3, 19.3.2.1.3, and NFPA 99 Standards for Health Care Facilities 2012 Edition section 11.3.4.2 These deficient conditions could have a patterned impact on the residents within the facility. Findings include: 1. On 10/05/2021, at 10:42 AM, during the facility tour observations revealed that there are 3 loose oxygen cylinders located in the oxygen storage room next to resident room 165. 2. On 10/05/2021, at 11:38 AM, during the facility tour observations revealed that the door to the oxygen storage room located within the memory care unit did not fully close and positively latch into the door frame. These deficient conditions were verified by the Maintenance Supervisor.	K 923	affected. Maintenance employees have been educated on ensuring oxygen cylinders are stored properly in oxygen rooms. Licensed Nurses and Certified Nursing Assistants have been educated on ensuring oxygen cylinders are stored properly in oxygen rooms. Monthly audits will be conducted for four months, then quarterly for 3 quarters. Audit results to be reviewed at monthly QAPI to evaluate the effectiveness of properly stored oxygen cylinders and the need for audit continuation. Adm/Director of Environmental Services or designee responsible for ensuring compliance. Corrective Date of Compliance: 11/12/2021	