Electronically delivered
July 1, 2021

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

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

Dear Administrator:

On June 17, 2021, a survey was completed at your facility by the Minnesota Departments of Health 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.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting

the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Kathleen Lucas, 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: kathleen.lucas@state.mn.us
Office: (320) 223-7343 Mobile: (320) 290-1155

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 the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by September 17, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by December 17, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245438	A. BUILDING _____ B. WING _____	C 06/17/2021

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
F 000	INITIAL COMMENTS On 6/16/21-6/17/21, a standard abbreviated survey was conducted at your facility. 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: H5438113C (MN00073311), with a deficiency cited at (F585) The following complaint was found to be SUBSTANTIATED, however NO deficiencies were cited due to actions implemented by the facility prior to survey: H5438107C (MN00070522) H5438108C (MN00071029) H5438109C (MN00070189) H5438110C (MN00070521) H5438111C (MN00072068) H5438112C (MN00071362) H5438116C (MN00073672) H5438117C (MN00073653) The following complaints were found to be UNSUBSTANTIATED: H5438114C (MN00072327) H5438115C (MN00073289) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/02/2021

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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F 000	Continued From page 1 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 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally	F 585		7/11/21

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F 585	Continued From page 2	F 585		

(meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a

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F 585	Continued From page 3 summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure voiced grievances of long call light times were addressed, acted upon and documented for 1 of 1 residents (R9) reviewed for grievances. Findings include: R9's quarterly Minimum Data Set (MDS) dated 4/5/21, indicated R9's speech was clear, was able to make herself understood and was able to understand others. R9 had no cognitive impairment and required limited physical assist from staff for transfers, dressing and toilet use. Facility record, Device Activity Report, for date 5/26/21, indicated the bath call light for room 177	F 585	For resident 9, a concern form was filled out by the Director of Nursing and added to the concern/grievance log. Resident was seen by the Director of Nursing to explain to her that we are doing call light audits and that she will be visited with weekly for one month and then monthly for 3 months to ensure that her concerns/call lights have been addressed timely. Also explaining to the resident that at any time she can fill out a concern/grievance form or we can assist her to complete the form. These visits will be completed by the Administrator. All residents upon admission will be trained on how to use the call light and will	

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F 585	Continued From page 4 (R9's room) was on for 76 minutes, 46 seconds. The call light for room 177, bed B (R9's roommate) was on for 155 minutes, 13 seconds. During interview on 6/16/21, at 2:09 p.m. R9 stated on 5/26/21 or 5/27/21 she was in the bathroom, in her room, after having a loose stool. She put the bathroom call light on for assistance. When staff did not respond for more than 30 minutes, she asked her roommate to put the room call light on. R9 stated staff did not answer either light for more than an hour. R9 indicated she had told the Director of Nursing (DON) about her concern but did not know what happened after their conversation. R9 stated long call light times continue to be a concern. On 6/17/21, at 11:54 a.m. DON confirmed she had talked with R9 regarding her concerns of staff response to her call light, specifically R9's concern when she was on the toilet for an extended period. DON stated she explained to R9 that staff were busy during specific times so call light times tend to be longer. DON stated she did not complete a grievance form because R9 assured her she understood and it wasn't a big deal. DON stated she did not review call light times for R9 or her roommate for the specific day and an audit was not completed. During this interview, DON reviewed call light times associated with R9's room and bathroom. DON confirmed the call times for 5/26/21 and stated, "that is a really long time." DON stated the call lights are checked weekly to ensure they are functioning properly. There was no reason to believe the call lights were not functioning properly on 5/26/21. On 6/17/21, at 1:09 p.m. the administrator stated	F 585	be visited by the Social Worker within 48 hours to ensure that they know our process on completing concerns/grievance forms. Residents receive upon admission to our home Edenbrook St. Cloud the policy and procedures of grievances. Call light audits started on June 16, 2021. Weekly audits for five weeks are being completed by the Inter-disciplinary team and turned into the Director of Nursing on a weekly basis. Weekly an analysis of the call light audits will be done by the Director of Nursing. Most recent analysis suggests that long wait times are isolated and most call wait times are from 30 seconds to 15 minutes. Grievance/concern/ information is posted on the three main bulletin boards throughout the facility on how to submit a grievance/concern or suggestion. A suggestion box is located just a bit east of our reception area where residents can fill out a form anonymously. Grievances/concerns are filled out on a concern form and can be completed by any employee, resident or family member. Edenbrook St. Cloud has a grievance policy, and it is posted on the three main bulletin boards though out the facility and at the reception desk as well as a document that states who a	

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F 585	Continued From page 5 she expected a grievance form be filled out with any concerns a resident or family may have. The form can be completed by the resident, by family or by staff on the resident's behalf. In the instance of the concern with long call lights, the administrator stated she would expect a grievance form was filled so it could be followed up on per their policy and procedure. According to facility policy and procedure, Grievance/Concerns revision date 12/3/18, at any time, comments, suggestions or complaints by the residents and/or their representatives are encouraged to direct their concerns to: The Administrator, Social Services Director, Director of Nursing or designee, or any appropriate manager.	F 585	grievance/concern/suggestion can be turned into. Those names are Hailey Anunson, Social Services, Edenbrook St. Cloud, 1717 University Drive SE., St. Cloud, MN 56304 or 320-251-9120 ext. 324, Krista Donabauer, RN, Director of Nursing, Edenbrook St. Cloud, 1717 University Drive SE., St. Cloud, MN 56304 or 320-251-9120 ext. 322 or Michele Halvorson, Administrator, Edenbrook St. Cloud, 1717 University Drive SE., St. Cloud, MN 56304 or 320-251-9120 ext. 309. Any other manager/employee can also receive the grievance/concern/suggestion form and direct it to the main grievance official who is the facility Social Worker Hailey Anunson. Weekly the Administrator or designee and Social Worker go over the grievances/concerns and check the suggestion box to ensure they are logged in the electronic log; residents have been updated on the grievance/concern and or representative and that follow up is documented on the form. The form then is signed by the Administrator. All grievance/concerns will be kept on file for 3 years. Any grievances/concerns/suggestions that are in any way of alleged violation involving neglect, abuse, including injuries of unknown sources, and/or misappropriation of resident property by anyone furnishing services on behalf of the provider, to the administrator of the	

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F 585	Continued From page 6	F 585	provider; and as required by State Law will be submitted as a vulnerable adult report and a 5-day investigation will be completed. Education was provided to all employees by way of a power point presentation covering the concern/grievance policy and procedures and signature sheet with date included. All new employees will also receive this information upon hire date. Education to be completed by July 11th, 2021. Residents will have this as a topic for education/information at their upcoming Resident Council meeting on July 22, 2021. Grievance audits will be completed to ensure that we have timely grievance follow-up. This audit will be completed by the Administrator or designee weekly for 1 month and then monthly for 3 months. All information will be brought to the monthly QAPI meetings. Completion date is July 11, 2021.	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 1, 2021

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

Re: Event ID: 1DFE11

Dear Administrator:

The above facility survey was completed on June 17, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 6/16/21-6/17/21 a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaint was found to be	2 000		

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2 000	Continued From page 1 UNSUBSTANTIATED: H5438114C (MN00072327) H5438115C (MN73289) The following complaint was found to be SUBSTANTIATED, however NO licensing orders were issued: H5438107C (MN00070522) H5438108C (MN00071029) H5438109C (MN00070189) H5438110C (MN00070521) H5438111C (MN00072068) H5438112C (MN00071362) H5438113C (MN00073311) H5438116C (MN00073672) H5438117C (MN00073653) Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		