



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 1, 2022

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

RE: CCN: 245438
Cycle Start Date: December 16, 2021

Dear Administrator:

On January 27, 2022, we notified you a remedy was imposed. On February 17, 2022 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of February 11, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective February 16, 2022 did not go into effect. (42 CFR 488.417 (b))

However, as we notified you in our letter of December 27, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 18, 2022. This does not apply to or affect any previously imposed NATCEP loss.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Joanne Simon', with a horizontal line extending to the right.

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Revised to show correct IJ tag removed

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December 27, 2021

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

RE: CCN: 245438
Cycle Start Date: December 16, 2021

Dear Administrator:

On December 16, 2021, a survey was completed at your facility by the Minnesota Department 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 delivered CMS-2567, whereby significant corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On November 18, 2021, the situation of immediate jeopardy to potential health and safety cited at F 689 was removed. It was determined that the facility had implemented actions to correct F 689 prior to the survey. As a result, the immediate jeopardy was cited as past noncompliance. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

REMEDIES

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

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 16, 2022.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 16, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 16, 2022.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

- 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.

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.**

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Talahi Nursing And Rehab Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective December 16, 2021. This prohibition remains in effect for the specified period even though substantial compliance is attained. 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 ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

DEPARTMENT CONTACT

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

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 16, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are

incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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/ltr_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,



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

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Saint Cloud, Minnesota 56301-4557
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Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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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

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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

PRINTED: 07/06/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245438		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/16/2021	
NAME OF PROVIDER OR SUPPLIER TALAH NURSING AND REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 12/15/21 - 12/16/21, 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: H5438132C (MN00079262), with a deficiency cited at F689 H5438133C (MN00079116), with no deficiency cited As a result of the investigation deficiencies were also cited at F609 and F610. The following complaints were found to be UNSUBSTANTIATED: H5438131C (MN00079297) The IJ began on 11/17/21, when R1 fell while being transferred in the Hoyer lift when the sling split open and R1 fell to the floor, sustaining minor injuries. The administrator and director of nursing (DON) were informed of the IJ on 12/16/21, at 5:53 p.m. The immediate jeopardy was removed, and the deficient practice corrected on 11/18/21, prior to the start of the survey and was therefore Past Noncompliance 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

12/29/2021

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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NAME OF PROVIDER OR SUPPLIER TALAH NURSING AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304		
(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	Continued From page 1	F 000			
F 609 SS=D	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. Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §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:	F 609			1/14/22

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

PRINTED: 07/06/2022
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F 609	Continued From page 2 Based on interview and document review the facility failed to report a resident fall from a Hoyer lift during provisions of care to the state agency (SA) for 1 of 2 residents (R1) reviewed. Findings include: R1's significant change Minimum Data Set (MDS) dated 9/25/21 indicated no cognitive impairments and required assistance of staff with transfers. R1's care plan dated 10/7/21, indicated R1 had impaired mobility related to his obesity. The care plan indicated R1 required assistance of 2 staff with Hoyer transfers and was non-ambulatory. On 12/13/21 a common entry point (CEP) was submitted to SA which indicated on 11/17/21, R1 was going to take a shower. Only one nursing assistance was using the Hoyer lift. R1 was up five feet, cleared bed and straps broke. R1 dropped five feet. On 11/17/21, at 9:00 p.m. a progress notes indicated R1 had a fall; at 9:15 p.m. another progress note indicated R1 had a bath/shower and had a fall. No further details were noted in progress notes. When interviewed on 12/16/21, at 10:16 a.m. director of nursing (DON) stated she completed the investigation when R1 fell on 11/17/21. DON stated the incident was not reported to the SA as R1 did not suffer any injuries. A facility policy Vulnerable Adult Abuse and Neglect Prevention dated 11/17/20, indicated if injury is unexplainable, or an allegation of abuse is reported or witnessed, if there is caregiver	F 609	R1: OHFC report submitted for the fall on 12/29/2021. All residents have the potential to be affected. Reviewed grievances and falls from the past month to ensure no items that should have been reported were missed. Staff educated on the importance of reporting all allegations of abuse and neglect to the Administrator and State Agency in a timely manner, regardless of perceived accuracy of the allegations. Weekly audits of grievances and falls will be conducted for one month to validate that no episodes of abuse or neglect have occurred. Audit results to be reviewed at monthly QAPI to evaluate the effectiveness of the plan of correction and to determine need for audit continuation. NHA/Designee is responsible for ensuring compliance. Corrective Date of Compliance: 1/14/2022		

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NAME OF PROVIDER OR SUPPLIER TALAH NURSING AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304		
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F 609	Continued From page 3 neglect, or if therapeutic error resulted in injury, a report must be made to the state health department immediately with initial findings.	F 609			
F 610 SS=D	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 facility failed to thoroughly investigate a resident fall from a Hoyer lift and sling malfunction which resulted in a fall. for 1 of 2 residents (R1) reviewed for falls. Findings include: R1's significant change Minimum Data Set (MDS) dated 9/25/21 indicated no cognitive impairments and required assistance of staff with transfers.	F 610			1/14/22
			- R1: OHFC report submitted on 12/29/2021 will have the final full investigation completed and submitted by 1/5/2022. - All residents have the potential to be affected. - Falls from the past month have been reviewed to ensure a thorough investigation has been conducted including but not limited to witness statements from applicable staff and residents, recreation of the fall scene to		

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F 610	Continued From page 4 R1's care plan dated 10/7/21, indicated R1 had impaired mobility related to his obesity. The care plan indicated R1 required assistance of 2 staff with Hoyer transfers and was non-ambulatory. On 11/17/21, at 9:00 p.m. a progress notes indicated R1 had a fall; at 9:15 p.m. another progress note indicated R1 had a bath/shower and had a fall. No further details were noted in progress notes. On 11/17/21. At 8:48 p.m. a facility risk assessment indicated an incident description from registered nurse (RN)-A was called to R1 rooms where R1 was on floor. Aide stated that the sling had ripped and R1 fell to floor. R1 voiced pain in left should, neck and right hip. R1 was alert and oriented. R1 was interviewed and agreed with aide description. R1 was immediately assess for bruises, RN-A did a neuro exam, and checked vitals. No bruises noted, nothing appeared to be broken. Sling replaced. No injuries were observed at time of incident. When interview on 12/15/21, at 11:50 a.m. R1 stated he was being transferred from his bed as he was getting a bath. R1 stated he was not interviewed about how the fall occurred. R1 stated he did not suffer any major injuries, only a sore shoulder. When interviewed on 12/16/21, at 10:16 a.m. director of nursing (DON) stated she completed the investigation when R1 fell on 11/17/21. DON stated it was unknown who was assisting R1 with the transfer. DON stated she did interview staff but did not document the interviews and did not recall who was interviewed. DON stated she did assess R1 pain the next day after the fall but did	F 610	help determine the root cause of the fall, and interventions to be put into place to decrease the potential of the fall occurring in the future. - NHA, DON, Nurse Managers, and Social Services Director educated on the need to ensure a thorough investigation is completed. - The investigation would include but is not limited to the resident statement, witness interviews, environmental factors, medication review as applicable, plan of care review, and review of current health status. The summary of investigation, root cause analysis, and intervention related to root cause will be included in the IDT post fall assessment. - Weekly audits of reportable items to ensure the investigation has been completed thoroughly to include witness statements of applicable staff and residents, recreation of the fall scene to help determine the root cause of the fall, and intervention put into place and noted on the care plan which addresses the root cause of the fall. - Audit results to be reviewed at monthly QAPI to evaluate the effectiveness of the plan of correction and to determine need for audit continuation. - NHA/Designee is responsible for ensuring compliance.		

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F 610	Continued From page 5 not interview on the incident. DON stated there is camera footage, but it was not reviewed as part of the investigation. DON stated the sling manufacturer was not consulted during the investigation. When interviewed on 12/16/21, at 11:19 a.m. assistance director of nursing (ADON) stated when she arrived after the fall there were three staff present but she was not sure who performed the transfer or how many were present during the actual fall adding she interviewed two of the three staff that were present after the fall. ADON did not document interviews, it was all verbal. ADON stated she did not interview R1. The facility investigation lacked evidence of interviews with the resident, staff and witnesses, review of care plan and/or steps the facility took to investigate possible causes for the resident fall, including contacting the manufacturer.	F 610			
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to have a preventative maintenance plan for resident Hoyer slings to ensure the integrity of the slings for safe resident	F 689	Past noncompliance: no plan of correction required.		

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F 689	Continued From page 6 use for 1 of 2 residents (R1) reviewed for accidents. This resulted in an immediate jeopardy (IJ) for R1 when the sling split open while R1 was being transferred in the Hoyer lift and he fell, sustaining minor injuries. The IJ began on 11/17/21, when R1 fell while being transferred in the Hoyer lift when the sling split open and R1 fell to the floor, sustaining minor injuries. The administrator and director of nursing (DON) were informed of the IJ on 12/16/21, at 5:53 p.m. The immediate jeopardy was removed, and the deficient practice corrected on 11/18/21, prior to the start of the survey and was therefore Past Noncompliance Findings include: R1's Diagnosis Information, undated, indicated R1's diagnoses included diabetes, unsteadiness on feet, other abnormalities of gait and mobility and morbid obesity. R1's significant change Minimum Data Set (MDS) dated 9/25/21 indicated no cognitive impairments and required assistance of staff with transfers. R1's care plan dated 10/7/21, indicated R1 had impaired mobility related to his obesity. The care plan indicated R1 required assistance of two staff with Hoyer transfers and was non-ambulatory. On 12/13/21, a common entry point (CEP) was submitted to state agency (SA) which indicated on 11/17/21, R1 was going to take a shower. Only one nursing assistant was using the Hoyer lift during the transfer. R1 was up five feet, cleared bed and straps broke. R1 dropped five feet.	F 689			

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F 689	Continued From page 7 On 11/17/21, at 9:00 p.m. a progress note indicated R1 had a fall; at 9:15 p.m. another progress note indicated R1 had a bath/shower and had a fall. No further details were noted in progress notes. On 11/17/21, at 8:48 p.m. a facility risk assessment indicated an incident description from registered nurse (RN)-A was called to R1's room where R1 was on floor. Aide stated that the sling had ripped and R1 fell to floor. R1 voiced pain in left shoulder, neck, and right hip. R1 was alert and oriented. R1 was interviewed and agreed with aide description. R1 was immediately assessed for bruises, RN-A did a neuro exam, and checked vitals. No bruises noted, nothing appeared to be broken. Sling replaced. No injuries were observed at time of incident. During observation and interview on 12/15/21, at 11:50 a.m. R1 was sitting in his wheelchair in his bedroom. R1 stated he was being transferred from his bed as he was getting ready for a bath. R1 stated only one nursing assistant was performing the transfer with the Hoyer lift. R1 stated he fell while in the sling and believed one of the loops ripped. R1 stated he was not interviewed about how the fall occurred. R1 stated he did not suffer any major injuries, only a sore shoulder. During observation R1's Hoyer sling was not observed in his room. When interviewed on 12/15/21, at 4:28 p.m. RN-A stated she completed the assessment after R1 fell, she was not a witness. RN-A stated the nurse aide came to her and stated R1 had fallen from the Hoyer and believed she was alone but did not remember which aide it was. RN-A stated the sling was removed by assistant director of	F 689			

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F 689	Continued From page 8 nursing (ADON) and given a new sling to use. RN-A stated she did not make a report to the State Agency. When interviewed on 12/16/21, at 10:16 a.m. director of nursing (DON) stated she completed the investigation when R1 fell on 11/17/21. DON stated it was unknown who was assisting R1 with the transfer. At request of survey staff, DON reviewed camera footage and it was identified at that time, only one aide preformed the Hoyer lift transfer resulting in a fall. DON stated it is policy to have a minimum of two staff assisting in a Hoyer transfer. DON stated the sling had been removed when it ripped during the transfer. DON stated after the incident the sling was thrown away and added they did not contact the manufacturer to report the malfunction of the sling. DON stated the sling was ripped on a loop and noted the rip was not at the seam but rather in the center of the fold of the loop. DON stated staff were re-educated on checking slings integrity before use, reviewed importance of following R1's care plan and reviewed facility policy. DON stated an audit was developed and completed for all slings which resulted in no concerns with the integrity of other slings in the facility. DON stated there was no audits performed on slings prior to this incident. DON stated the incident was not reported to the SA as R1 did not suffer any injuries. When interviewed on 12/16/21, at 11:19 a.m. assistance director of nursing (ADON) stated she worked the day of R1's fall on 11/17/21. ADON stated she was called to R1's room after the fall occurred and assisted getting R1 off the floor. ADON stated when she arrived after the fall there were three staff present but was not sure who	F 689			

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F 689	Continued From page 9 performed the transfer or how many were present, ADON did not investigate with staff interviews. Phone call interview on 12/16/21, at 1: 25 p.m. with sling manufacturer INVOCARE representative who stated when a facility had an incident with a sling, they would want all incidents reported and would want the sling sent back so they could complete their own investigation to determine the cause of the fall/rip. During observations on 12/16/21, starting at 3:25 p.m. two separate resident Hoyer lift transfers were observed with no concerns regarding sling integrity or care plan implementation noted. Nursing assistant (NA)-A was attempted to be interviewed for this survey; calls were not returned. On 11/18/21, facility provided education on sling integrity with all floor staff. On 11/18/21, facility administered a Hoyer sling integrity audit resulting in no other issues with the slings in the facility. R1's sling was removed and provided a new sling. Facility's Policy and Procedure Using a Mechanical Lift dated 8/1/15, indicated the portable lift should be used by two nursing assistants to perform the procedure. Facility's Policy and Procedures Post Fall Policy dated 3/23/20, indicated to complete a Risk Management incident. The report should include but is not limited to the following information: residents account of the incident.	F 689			

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F 689	Continued From page 10 The past non-compliance immediate jeopardy began on 11/17/21. The immediate jeopardy was removed, and the deficient practice corrected by 11/18/21, after the facility implemented education with all staff concerning implementation of care plan needs of residents, integrity of slings, removal of the malfunctioned sling and current and ongoing audits of all the slings in use at the facility. Audits concluded no other slings were malfunctioning. Verification was identified onsite through interview, observation, and record review.	F 689			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 27, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: BHI511

Dear Administrator:

The above facility was surveyed on December 15, 2021 through December 16, 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:

**Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334**

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

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,



Joanne Simon, Enforcement Specialist
Minnesota Department of Health
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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00614	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/16/2021
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2 000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 12/15/21 - 12/16/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

12/29/21

Minnesota Department of Health

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2 000	Continued From page 1 The following complaints were found to be SUBSTANTIATED: H5438132C (MN00079262), with a licenising order cited at 1665 H5438133C (MN00079116), with no licensing order cited The following complaints were found to be UNSUBSTANTIATED: H5438131C (MN00079297) 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. 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/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box	2 000			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00614	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 12/16/2021
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2 000	Continued From page 2 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	2 000			
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to have a preventative maintenance plan for resident Hoyer slings to ensure the integrity of the slings for safe resident use for 1 of 2 residents (R1) reviewed for accidents. This resulted in an immediate jeopardy (IJ) for R1 when the sling split open while R1 was being transferred in the Hoyer lift and he fell, sustaining minor injuries. The IJ began on 11/17/21, when R1 fell while being transferred in the Hoyer lift when the sling split open and R1 fell to the floor, sustaining minor injuries. The administrator and director of	21665	Corrected		1/14/22

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21665	Continued From page 3 nursing (DON) were informed of the IJ on 12/16/21, at 5:53 p.m. The immediate jeopardy was removed, and the deficient practice corrected on 11/18/21, prior to the start of the survey and was therefore Past Noncompliance Findings include: R1's Diagnosis Information, undated, indicated R1's diagnoses included diabetes, unsteadiness on feet, other abnormalities of gait and mobility and morbid obesity. R1's significant change Minimum Data Set (MDS) dated 9/25/21 indicated no cognitive impairments and required assistance of staff with transfers. R1's care plan dated 10/7/21, indicated R1 had impaired mobility related to his obesity. The care plan indicated R1 required assistance of two staff with Hoyer transfers and was non-ambulatory. On 12/13/21, a common entry point (CEP) was submitted to state agency (SA) which indicated on 11/17/21, R1 was going to take a shower. Only one nursing assistant was using the Hoyer lift during the transfer. R1 was up five feet, cleared bed and straps broke. R1 dropped five feet. On 11/17/21, at 9:00 p.m. a progress note indicated R1 had a fall; at 9:15 p.m. another progress note indicated R1 had a bath/shower and had a fall. No further details were noted in progress notes. On 11/17/21, at 8:48 p.m. a facility risk assessment indicated an incident description from registered nurse (RN)-A was called to R1's room where R1 was on floor. Aide stated that the sling had ripped and R1 fell to floor. R1 voiced	21665		

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21665	Continued From page 4 pain in left shoulder, neck, and right hip. R1 was alert and oriented. R1 was interviewed and agreed with aide description. R1 was immediately assessed for bruises, RN-A did a neuro exam, and checked vitals. No bruises noted, nothing appeared to be broken. Sling replaced. No injuries were observed at time of incident. During observation and interview on 12/15/21, at 11:50 a.m. R1 was sitting in his wheelchair in his bedroom. R1 stated he was being transferred from his bed as he was getting ready for a bath. R1 stated only one nursing assistant was performing the transfer with the Hoyer lift. R1 stated he fell while in the sling and believed one of the loops ripped. R1 stated he was not interviewed about how the fall occurred. R1 stated he did not suffer any major injuries, only a sore shoulder. During observation R1's Hoyer sling was not observed in his room. When interviewed on 12/15/21, at 4:28 p.m. RN-A stated she completed the assessment after R1 fell, she was not a witness. RN-A stated the nurse aide came to her and stated R1 had fallen from the Hoyer and believed she was alone but did not remember which aide it was. RN-A stated the sling was removed by assistant director of nursing (ADON) and given a new sling to use. RN-A stated she did not make a report to the State Agency. When interviewed on 12/16/21, at 10:16 a.m. director of nursing (DON) stated she completed the investigation when R1 fell on 11/17/21. DON stated it was unknown who was assisting R1 with the transfer. At request of survey staff, DON reviewed camera footage and it was identified at that time, only one aide performed the Hoyer lift transfer resulting in a fall. DON stated it is policy	21665			

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21665	Continued From page 5 to have a minimum of two staff assisting in a Hoyer transfer. DON stated the sling had been removed when it ripped during the transfer. DON stated after the incident the sling was thrown away and added they did not contact the manufacturer to report the malfunction of the sling. DON stated the sling was ripped on a loop and noted the rip was not at the seam but rather in the center of the fold of the loop. DON stated staff were re-educated on checking slings integrity before use, reviewed importance of following R1's care plan and reviewed facility policy. DON stated an audit was developed and completed for all slings which resulted in no concerns with the integrity of other slings in the facility. DON stated there was no audits performed on slings prior to this incident. DON stated the incident was not reported to the SA as R1 did not suffer any injuries. When interviewed on 12/16/21, at 11:19 a.m. assistance director of nursing (ADON) stated she worked the day of R1's fall on 11/17/21. ADON stated she was called to R1's room after the fall occurred and assisted getting R1 off the floor. ADON stated when she arrived after the fall there were three staff present but was not sure who performed the transfer or how many were present, ADON did not investigate with staff interviews. Phone call interview on 12/16/21, at 1: 25 p.m. with sling manufacturer INVOCARE representative who stated when a facility had an incident with a sling, they would want all incidents reported and would want the sling sent back so they could complete their own investigation to determine the cause of the fall/rip. During observations on 12/16/21, starting at 3:25	21665		

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21665	Continued From page 6 p.m. two separate resident Hoyer lift transfers were observed with no concerns regarding sling integrity or care plan implementation noted. Nursing assistant (NA)-A was attempted to be interviewed for this survey; calls were not returned. On 11/18/21, facility provided education on sling integrity with all floor staff. On 11/18/21, facility administered a Hoyer sling integrity audit resulting in no other issues with the slings in the facility. R1's sling was removed and provided a new sling. Facility's Policy and Procedure Using a Mechanical Lift dated 8/1/15, indicated the portable lift should be used by two nursing assistants to perform the procedure. Facility's Policy and Procedures Post Fall Policy dated 3/23/20, indicated to complete a Risk Management incident. The report should include but is not limited to the following information: residents account of the incident. The past non-compliance immediate jeopardy began on 11/17/21. The immediate jeopardy was removed, and the deficient practice corrected by 11/18/21, after the facility implemented education with all staff concerning implementation of care plan needs of residents, integrity of slings, removal of the malfunctioned sling and current and ongoing audits of all the slings in use at the facility. Audits concluded no other slings were malfunctioning. Verification was identified onsite through interview, observation, and record review.	21665			

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21665	Continued From page 7 SUGGESTED METHOD OF CORRECTION: The administrator, maintenance supervisor, or designee could ensure a preventative maintenance program was developed to accurately reflect ongoing preventative maintenance scheduled or needed in the facility on a routine basis. The facility could create policies and procedures, educate staff on these changes and perform environmental rounds/audits periodically to ensure preventative maintenance is adequately completed. The facility could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21665			