



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



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March 1, 2022

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

Re: Reinspection Results
Event ID: TE2P12

Dear Administrator:

On February 17, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on February 17, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Joanne Simon', with a long 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
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February 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 December 27, 2021, we informed you of imposed enforcement remedies.

On January 18, 2022, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted immediate jeopardy (Level J), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY (delete if not IJ)

On January 18, 2022, the situation of immediate jeopardy to potential health and safety cited at F689 was removed. However, continued non-compliance remains at the lower scope and severity of D.

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective February 16, 2022.
- Directed plan of correction, Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

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 February 16, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 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.

As we notified you in our letter of December 27, 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 February 16, 2022.

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 February 16, 2022. 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 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 "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 (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)

Talahi Nursing And Rehab Center

February 1, 2022

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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/lrc_idr.cfm

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

https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Feel free to contact me if you have questions.

Sincerely,



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: 08/23/2022
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 01/18/2022
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 Revised 2567 as a Result of an Informal Dispute Resolution: On 1/13/22 , through 1/18/22, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found NOT to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5438140C (MN80214) with deficiencies issued at F550 and F689; H5438136C (MN79841) with a deficiency issued at F677. The following complaint was found to be unsubstantiated: H5438137C (MN79839) H5438138C (MN80040) H5438139C (MN79731, MN79975, MN79981 & MN79996) Additionally, as a result of the investigation, a deficiency at F609 was issued. 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, a revisit of your facility will be conducted to validate substantial compliance with the regulations has been attained in accordance with your verification.	F 000			
F 550	Resident Rights/Exercise of Rights	F 550			2/11/22

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

TITLE

(X6) DATE

Electronically Signed

02/07/2022

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 550 SS=D	Continued From page 1 CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her	F 550			

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F 550	Continued From page 2 rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure assistance with cares were completed to maintain dignity for 1 of 1 residents (R5) who required staff assistance with cares. Findings include: R5's significant change Minimum Data Set (MDS) dated 1/7/22, indicated he was cognitively intact, had no behaviors, no wandering, required extensive assist of two with bed mobility, transfers and toileting and assist of one with personal hygiene and eating. R5's care plan dated 12/28/21, indicated for activities of daily living (ADL)'s R5 had impaired balance, limited mobility and was a quadriplegic (paralysis of the arms and legs caused by neurological damage). In addition R5's care plan indicated he required extensive assistance with personal hygiene. R5's Occupational Therapy assessment dated 10/5/21, indicated R5 had quadriplegia, alcohol addiction and abuse, nicotine dependence, depression and anti-social personality disorder (a mental disorder in which a person consistently shows no regard for right and wrong and ignores the rights and feelings of others). The assessment further indicated R5 lacked capacity for chronic disease management and lacked insight into condition. During observation 1/13/22, at 10:14 a.m. R5 was	F 550	R5: Upon notification to the staff, resident's door was closed to provide him privacy. Curtain was offered and resident declined. All residents have the potential to be affected. Staff educated on the Privacy and Dignity policy. Weekly audits x 1 month of 10 residents per week will be completed to ensure residents cares are being met with privacy and dignity. Audit results to be reviewed at monthly QAPI to evaluate the effectiveness of the plan of correction and to determine need for audit continuation. DON/Designee is responsible for ensuring compliance. Corrective Date of Compliance: 2/11/2022		

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F 550	Continued From page 3 observed from his room lying in bed next to the window from the hallway with no clothing from the waist down he was yelling "Can I get up! Will someone help me!" Surveyor entered room and R5 was observed to be unclothed from the waist down. R5's genitalia was observed and colostomy bag. Surveyor left room as R5 stated he wanted to talk later after he was up in his wheelchair. Approximately three minutes later while R5 was still yelling, licensed practical nurse (LPN)-A was observed to walk into the room and talk to R5 for 20 seconds and left R5's room without covering R5 and leaving R5's room with his door open the entire time. Approximately two minutes later LPN-A returned to move R5's wheelchair and housekeeping arrived to mop his floor due to pop which was spilled on his floor. During the entire observation R5's door was never shut and R5 was never covered for privacy. During interview 1/13/22, at 3:00 p.m. R5 stated he had just moved into his room and was not aware anyone could see him from the door and if he knew staff or visitors could see him it would definitely bother him. In addition R5 stated "I think sometimes the staff just forget to shut the door or cover me up but it does upset me". During interview 1/18/22, at 9:30 a.m. LPN-A stated she was caring for R5 on 1/13/22, and was in and out of the room in the morning and remembered not shutting the door and really did not notice R5 was uncovered and if she did she should have covered R5 up or shut the door for dignity purposes. LPN-A stated she should look closer at the residents when she enters the room to make sure they are fully covered. Facility policy Privacy and Dignity dated 1/10/22,	F 550			

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F 550	Continued From page 4	F 550			
F 609	indicated "Privacy is provided during cares and resident is appropriately covered"				
SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4)	F 609			2/11/22
	§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: Based on interview and document review, the facility failed to report to the state agency (SA) for 1 of 1 resident's who required supervision on		R5: OHFC report submitted for the 1/14/2022 elopement. All residents have the potential to be		

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F 609	Continued From page 5 facility grounds who left the facility unsupervised and was found intoxicated at a near by gas station and required emergency medical treatment for alcohol intoxication. Findings include: R5's Face Sheet undated, indicated R5 admitted to the facility on 7/16/21. R5's Care Plan revised 11/22/21, indicated R5 was considered a vulnerable adult due to his cognitive and functional deficits and was not to leave the facility without supervision from his guardians or aunt, and R5 refuses to comply with plan to not leave the facility unsupervised without his guardians or aunt. (date initiated 8/17/21). R5's significant change Minimum Data Set (MDS) dated 1/7/22, indicated he was cognitively intact, had no behaviors, no wandering, required extensive assist of two with bed mobility, transfers and toileting and assist of one with personal hygiene and eating. R5's MDS further indicated he received antidepressant medications (used to address symptoms of depression), antipsychotic medications (used to manage psychosis, including delusions, hallucinations, paranoia or disordered thought) and hypnotic medications (produce sleep). R5's Wandering Risk Scale assessment dated 7/16/21, indicated R5 was dependent on activities of daily living (ADL)'s, and cannot move with out assistance and required assistance from staff for transfers and was independent with the use of an electric wheelchair. The assessment further indicated R5 was at low risk for wandering. R5's Risks vs Benefits assessment dated	F 609	affected. Reviewed elopement events for the past month to ensure no other items were missed from a reporting standpoint. Reviewed grievances for the past month to ensure no other potentially reportable allegations have been missed in reporting. Administrator, DON, ADON, and Nurse Manager educated on the Elopement Policy and the Abuse Policy. Weekly audits of elopement events to be completed x 1 month to ensure items which need to be reported are reported timely. Weekly audits of grievances and incidents to be completed x 1 month to ensure reportable items have been reported per regulation. 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: 2/11/2022		

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F 609	Continued From page 6 8/17/21, indicated a recommendation R5 would not leave facility unsupervised by nursing staff and nurse practitioner due to high risk for abuse by others and exploitation due to his cognition and quadriplegia diagnosis. In addition, the assessment indicated R5's guardian agreed with the plan not to allow R5 to leave the facility without supervision however, the guardian did express R5 "is going to do what [R5] wants to do". Review of R5's progress notes indicated on 8/27/21, the facility received a phone call from St. Cloud police that R5 was found at a nearby gas station. R5's speech was mumbled and did not appear to be able to safely drive himself back to the facility in his motorized wheelchair. He was sent to the emergency room (ER) and treated for alcohol toxicity. Review of R5's record there was no report made to the state agency of R5's incident occurrence that occurred on 8/27/21. During interview 1/13/22, at 4:05 p.m. assistant director of nursing (ADON) stated she had concerns with R5 leaving the facility and coming back smelling like Marijuana along with his old roommate. The ADON stated he was hospitalized in the past for alcohol intoxication. The ADON stated he will make phone calls and go off the facility grounds to buy marijuana which they would then confiscate from him. During interview on 1/14/22, at 1:00 p.m. the director of nursing (DON) stated R5 had a motor vehicle accident in his teens and was diagnosed with a Traumatic Brain Injury following the car accident and now used a motorized wheelchair	F 609			

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F 609	Continued From page 7 for mobility. The DON stated she was unsure how he obtained the alcohol for his 8/27/21, ER visit. Further the DON stated R5 had made plans to go get medical marijuana that day (8/27) and his dad said he could not go, so the facility canceled his cab. The DON stated the facility was aware R5 was upset and took off (left campus unsupervised) but did not consider this an elopement. He was found later at the gas station very intoxicated by the police. The DON stated she never really thought these incidents were reportable and after thinking according to policy they probably should have been. A facility Policy Abuse and Prevention Program revised 1/10/22, indicted all residents are protected from abuse, neglect and harm while they are residing at the facility and no harm of any type will be tolerated. In addition the policy indicated a mandated reporter shall make a report to the state reporting agency immediately of the alleged incident!	F 609			
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure assistance was provided with routine grooming and personal hygiene for 1 of 3 residents (R1) who was dependent on staff for grooming and nail care reviewed for activities of daily living (ADLs).	F 677	R1: Care plan has been updated with ADL assistance and grooming has been offered to resident. All residents have the potential to be affected. Completion of an initial review of residents to ensure nails are trimmed, hair combed and shaved, per the resident's		2/11/22

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F 677	Continued From page 8 Findings include: R1's discharge Minimum Data Set (MDS), dated 12/31/21, indicated R3 was cognitively intact. In addition, the MDS identified R1 required extensive assistance for personal hygiene which included combing hair, shaving, washing/drying of hands. R1's care plan dated 1/4/22, did not address R1's ADL function and required assistance with grooming. On 1/13/22, at 9:57 a.m. R1 was observed in his bed looked disheveled with long facial hair and fingernails. Underneath the fingernails was a large amount of dirt. Also R1 had multiple small scratches and scabs on his left forearm and elbow. On 1/13/22, at 11:22 a.m. interviewed R1's power of attorney (POA) who stated R1 was never groomed and had long facial hair and dirty long fingernails. The POA stated she brought a razor for staff to use but they were not using it and R1 appeared disheveled all the time. The POA further stated she did not like seeing R1 not well groomed. -At 12:10 p.m. the POA stated R1 had always been a "picker" ever since he was a child and gets scratches and scabs on his left arm frequently. POA then stated maybe R1 would not have as many scratches and scabs if the fingernails were kept short. On 1/13/22, at 12:15 p.m. interviewed POA's fiancé who stated he had known R1 for a long time and when he and the POA visited R1 he always appeared disheveled with long head hair,	F 677	preference. Nursing staff educated on the need to ensure grooming and nail care are offered to all residents. Weekly audits completed x 1 month for 10 residents to ensure grooming and nail care are offered to residents. Audit results to be reviewed at monthly QAPI to evaluate the effectiveness of the plan of correction and to determine need for audit continuation. DON/Designee is responsible for ensuring compliance. Corrective Date of Compliance: 2/11/2022		

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F 677	Continued From page 9 facial hair and fingernails and R1 had always been a clean shaven person and well-kept prior to his admission to the facility. On 1/14/22, at 9:20 a.m. interviewed R1 who stated they had not cut his fingernails or facial hair. R1 appeared as he did on 1/13/22. R1 stated he had not gotten a shower in a long time, but staff did clean him up some with some towels while in his bed the previous day on 1/13/22. On 1/14/22, at 9:25 a.m. interviewed nursing assistant (NA)-A who stated R1 received his bath on 1/13/22, which was his bath day scheduled one time per week. NA-A stated she was not aware of any bathing concerns for R1. NA-A stated R1 was a full assist for most cares including grooming. On 1/14/22, at 10:09 a.m. interviewed licensed practical nurse (LPN)-A who stated R1 does refuse cares sometimes. She then stated how staff approached R1 was important for and she could typically convince R1 to allow cares. LPN-A further stated R1 had been allowing bed baths and R1 required full assist for ADLs and grooming. On 1/14/22, at 12:20 p.m. interviewed the director of nurse (DON) who stated she was unaware of concerns with R1's grooming. The DON stated grooming should be done with his weekly bathing. The DON acknowledged R1's care plan was incomplete and had not been properly updated after the recent re-admission to the facility on 1/3/22. DON acknowledged R1's long fingernails were contributing to the left arm scratches and scabs. The DON further stated staff should be making sure R1's grooming got done.	F 677			

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F 677	Continued From page 10	F 677			
F 689 SS=J	The facility Policy and Procedure Activities of Daily Living, dated 3/15/21, indicated the facility will provide a comprehensive assessment of a residents to identify needs and choices. In addition, the policy indicated the facility will provide care and services for the following ADLs: hygiene, mobility, elimination, dining and communication. 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 comprehensively develop appropriate interventions to ensure adequate supervision was provided to prevent known off-campus activities which increased the risk of harm and/or injury for 1 of 1 resident (R5) assessed and care planned to require supervision in the community and identified to repeatedly be leaving the nursing home to purchase and/or use alcohol and marijuana (an illegal psychoactive drug). These findings constituted an immediate jeopardy (IJ) situation for R5. The IJ began on 8/27/21, when R5 left the nursing home campus and was later found at a gas station intoxicated by the local police	F 689	- R5: The following immediate actions taken: - Met with resident R5 guardian and developed a plan for supervised smoking and outings for resident on 1/14/2022. - Resident R5 informed of the agreed upon plan for supervised smoking and outings on 1/14/2022 - Staff education initiated on the plan for supervised smoking and outings for resident on 1/14/2022. Staff will be educated prior to their next shift worked if not educated on 1/14/2022. - Resident R5 care plan was updated with the agreed upon interventions on 1/14/2022.	2/11/22	

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F 689	Continued From page 11 department. R5 demonstrated mumbled speech and was unable to safely operate his electric scooter. R5 was returned to the nursing home; however, was not comprehensively or accurately reassessed for his "wander" risk nor were interventions placed to ensure adequate supervision. This resulted in R5 repeatedly leaving the campus, purchasing, and using alcohol and/or marijuana which increased his risk of serious injury or harm while off-campus. The administrator and director of nursing (DON) were notified of the IJ for R5 on 1/14/22, at 4:35 p.m. The IJ was removed on 1/18/22, at 11:35 a.m. after an acceptable removal plan was implemented, however, non-compliance remained at an isolated pattern with potential for more than minimal harm which is not immediate jeopardy (Level D). Findings include: R5's Face Sheet undated, indicated R5 admitted to the facility on 7/16/21. R5's Care Plan revised 11/22/21, indicated R5 was considered a vulnerable adult due to his cognitive and functional deficits and was not to leave the facility without supervision from his guardians or aunt, and R5 refuses to comply with plan to not leave the facility unsupervised. (date initiated 8/17/21). R5's significant change Minimum Data Set (MDS) dated 1/7/22, indicated he was cognitively intact, had no behaviors and no wandering. R5's MDS further indicated he received antidepressant medications (used to address symptoms of depression), antipsychotic medications (used to manage psychosis, including delusions,	F 689	o Agreed upon plan: ¿ R5 will be allowed supervised times outside during scheduled smoking session daily at 0930, 1330, 1600 and 1900. ¿ R5 will be allowed supervised smoking times at the above listed times. ¿ R5 will remain on Edenbrook St. Cloud property and within the designated smoking area outside of Fire Side. ¿ When R5 leaves Edenbrook St. Cloud property unsupervised all staff are instructed to call 911 to report Vulnerable Adult safety concerns. ¿ R5 is allowed to leave Edenbrook St. Cloud supervised with his mother, father, and aunt. ¿ When R5 leaves Edenbrook St. Cloud with the above named they will sign him out and assume responsibility of Jason. ¿ When R5 returns to Edenbrook St. Cloud from said supervised outing the named above, they will sign him in. • All residents have the potential to be affected. All residents have had a new Wander Risk Assessment completed to validate their elopement risk. Residents identified at risk for elopement have had their care plans reviewed and updated to ensure appropriate interventions are in place. Residents identified at risk have been added to the Elopement Binder. • House wide audit was completed for all residents to validate if guardianship was in place and to validate the paperwork was in the medical record. • Staff educated on the Elopement Policy and the Elopement Process listed below.		

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F 689	Continued From page 12 hallucinations, paranoia or disordered thought) and hypnotic medications (produce sleep). R5's Wandering Risk Scale assessment dated 7/16/21, indicated R5 was dependent on activities of daily living (ADL)'s, and cannot move with out assistance and required assistance from staff for transfers and was independent with the use of an electric wheelchair. The assessment further indicated R5 was at low risk for wandering. R5's Risks vs Benefits assessment dated 8/17/21, recommended R5 would not leave facility unsupervised due to high risk for abuse by others and exploitation due to his cognition and quadriplegia diagnosis. In addition, the assessment indicated R5's guardian agreed with the plan not to allow R5 to leave the facility without supervision however, the guardian did express R5 "is going to do what [R5] wants to do." R5's Occupational Therapy assessment dated 10/5/21, indicated R5 had quadriplegia (paralysis of the arms and legs caused by neurological damage), alcohol addiction and abuse, nicotine dependence, depression and antisocial personality disorder (a mental disorder in which a person consistently shows no regard for right and wrong and ignores the rights and feelings of others). The assessment further indicated R5 lacked capacity for chronic disease management and lacked insight into condition. R5's Medical History undated, indicated he was diagnosed with quadriplegia and a traumatic brain injury following a car accident and uses a mobilized wheelchair for mobility.	F 689	- Elopement drills will be completed each shift by 1/17/2022. Then weekly elopement drills will be completed x 4 weeks on rotating shifts, then will decrease to monthly drills. - Elopement policy reviewed with the Interdisciplinary Team, including but not limited to the Administrator, Director of Nursing, Social Services, Nurse Managers. - Audits will be completed weekly x 1 month to validate that resident at risk for elopement are in the Elopement Binder and their care plan interventions are in place and followed. - Weekly audit of guardianship paperwork to be completed for any new admissions and changes in guardianship status x 1 month. - Audit results to be reviewed at monthly QAPI to evaluate the effectiveness of the plan of correction and to determine need for audit continuation. - DON/Designee is responsible for ensuring compliance. - Corrective Date of Compliance: 2/11/2022		

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F 689	Continued From page 13 Review of R5's progress notes indicated on 8/27/21, the facility received a phone call from St. Cloud police that R5 was found at a nearby gas station. R5's speech was mumbled and did not appear to be able to safely drive himself back to the facility in his motorized wheelchair. He was sent to the emergency room (ER) and treated for alcohol toxicity. During interview 1/13/22, at 4:05 p.m. assistant director of nursing (ADON) stated she had concerns with R5 leaving the facility and coming back smelling like marijuana along with his old roommate. The ADON stated he was hospitalized in the past for alcohol intoxication. The ADON stated he will make phone calls and go off the facility grounds to buy marijuana which they would then confiscate from him. During interview on 1/14/22, at 1:00 p.m. the director of nursing (DON) stated R5 had a motor vehicle accident in his teens and was diagnosed with a traumatic brain injury following the car accident and now used a motorized wheelchair for mobility. The DON stated she was unsure how he obtained the alcohol for his 8/27/21, ER visit. Further the DON stated R5 had made plans to go get medical marijuana that day (8/27) and his dad said he could not go, so the facility canceled his cab. The DON stated the facility was aware R5 was upset and took off (left campus unsupervised) but did not consider this an elopement. He was found later at the gas station very intoxicated by the police. During interview on 1/14/22, at 11:39 a.m. receptionist stated she was informed about 2 weeks ago that she could let R5 leave the building to smoke and was given no instruction to	F 689			

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F 689	Continued From page 14 observe him. She stated she was unable to see him or keep him in her line of sight while he was outside. She does not keep track of how long he was outside or when/if he returns. During observation and interview on 1/14/22, at approximately 11:00 a.m. surveyor was informed R5 had left the facility and the DON had just called 911. Both surveyor and ADON went outside and found R5 driving down the middle of the road in his motorized wheelchair toward the facility during moderate snow fall, with difficult visibility. R5 was observed to be wearing just a sweatshirt and pants with footwear, no jacket or other outerwear. The temperature was 10 degrees. The facility was unsure what time R5 may have left the building that morning. -while outside looking for R5, the ADON pointed out a secured smoking area that was monitored by staff. Later at 3:30 p.m. the ADON was interviewed and asked why R5 does not use the secured smoking area, at which time the RN manager stated that R5 "does what he wants, when he wants." During interview on 1/14/22, at 2:10 p.m. the DON stated R5 had left the facility unsupervised at least 5 times since admission. The DON further indicated on multiple occasions he was found with marihuana they had to confiscate from him. Record review of R5's drug screening indicated on 8/12/21, 8/27/21, and 12/28/21, R5 tested positive for tetrahydrocannabinol (THC). During interview on 1/14/22, at 2:53 p.m. nursing assistant (NA)-B stated R5 was allowed to go	F 689			

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F 689	Continued From page 15 outside for about 10 minutes. She is not sure who monitors him, it would have to be the person who let him out. NA-B indicated she received training that R5 and his roommate could go outside but had to have coats on first. She was not aware they had to be supervised. Review of Realis computer training records indicated on 1/7/22, R5 and his roommate can go outside for 10 minutes if they put a coat on. Communication to employees lacked evidence R5 required supervision if leaving the facility as indicated in his Care Plan. During interview on 1/14/22, at 2:57 p.m. licensed practical nurse (LPN)-B stated R5 was allowed to leave the facility. In addition, LPN-B stated with his behavior changes they are reassessing if this should be allowed. LPN-B also stated that today he had an incident and they did not know where he was so they had to call 911. During interview on 1/14/22, at 3:04 p.m. ADON stated R5 was able to go outside for 10 minutes and could not leave the grounds, and needs supervision per his guardian. Furthermore the ADON stated she just had gotten off the phone with R5's dad minutes before this interview and stated his dad does not want him to be leaving the facility grounds because he engages in self destructive behavior such as heavy drinking, drugs, ect. and R5 is very difficult to work with. In addition, the ADON stated she had been instructed when R5 leaves the facility it was not considered an elopement since he had a destination he was going to. During interview at 1/14/22, at 3:30 p.m. the DON stated the facility does not have any formal plans	F 689			

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F 689	Continued From page 16 for when R5 leaves the facility grounds to direct the staff what to do if they suspect he had been under the influence of alcohol or drugs. In addition the DON stated they were not following the care plan as stated and should have had a better system in place for staff to be monitoring when R5 was leaving and returning, including the staff at the front desk monitoring his exit. During interview 1/17/22, at 11:00 a.m. R5's guardian stated he does not want R5 to leave the facility grounds without supervision since he does not make safe decisions. The facility's Elopement Policy revised 9/2/21, indicated, "It is the policy of this facility that all residents are afforded adequate supervision to provide the safest environment possible. All residents will be assessed for behaviors or conditions that put them at risk for wandering/elopement. All residents identified will have these issues addressed in their individual care plan." The IJ which began on 8/27/21, was removed on 1/18/22 at 11:28 a.m., when the facility successfully implemented a removal plan which included reviewing the applicable policies and procedures, ensured all residents were reassessed and care planned for their elopement risks and needs, and ensured all facility tools (i.e. w binder) were updated with current, correct information to help staff ensure safety and prevent elopements of residents identified to be at risk and those at risk are supervised. On 1/18/22, from approximately 9 a.m. to 11:00 a.m. direct care staff were interviewed and verified education had been completed and systems were in place to ensure residents were not at continued	F 689			

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

PRINTED: 08/23/2022
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 01/18/2022
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 689	Continued From page 17 significant risk of elopement and those at risk are supervised but, non-compliance remained at an isolated pattern with potential for more than minimal harm which is not immediate jeopardy (Level D).	F 689			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 1, 2022

Administrator

Talahi Nursing And Rehab Center

1717 University Drive Southeast

Saint Cloud, MN 56304

Re: Event ID: TE2P11

Dear Administrator:

The above facility survey was completed on January 18, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

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

Please feel free to call me with any questions.

Sincerely,

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

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 01/18/2022
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2 000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 1/13/22 through 1/18/22, 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. The following complaints were found to be	2 000		

Minnesota Department of Health

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

TITLE

(X6) DATE

Electronically Signed

02/07/22

Minnesota Department of Health

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2 000	Continued From page 1 SUBSTANTIATED: H5438140C (MN80214) with orders issued at 0830 and 1805; H5438139C (MN79731, MN79975, MN79981 & MN79996) with no orders issued; H5438136C (MN79841) with an order issued at 0830. The following complaint was found to be unsubstantiated: H5438137C (MN79839) H5438138C (MN80040) 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 evidenced 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

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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		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively develop appropriate interventions to ensure adequate supervision was provided to prevent	2 830	Corrected	2/11/22

Minnesota Department of Health

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2 830	Continued From page 3 known off-campus activities which increased the risk of harm and/or injury for 1 of 1 resident (R5) assessed and care planned to require supervision in the community and identified to repeatedly be leaving the nursing home to purchase and/or use alcohol and marijuana (an illegal psychoactive drug). These findings constituted an immediate jeopardy (IJ) situation for R5. The IJ began on 8/27/21, when R5 left the nursing home campus and was later found at a gas station intoxicated by the local police department. R5 demonstrated mumbled speech and was unable to safely operate his electric scooter. R5 was returned to the nursing home; however, was not comprehensively or accurately reassessed for his "wander" risk nor were interventions placed to ensure adequate supervision. This resulted in R5 repeatedly leaving the campus, purchasing, and using alcohol and/or marijuana which increased his risk of serious injury or harm while off-campus. The administrator and director of nursing (DON) were notified of the IJ for R5 on 1/14/22, at 4:35 p.m. The IJ was removed on 1/18/22, at 11:35 a.m. after an acceptable removal plan was implemented, however, non-compliance remained at an isolated pattern with potential for more than minimal harm which is not immediate jeopardy (Level D). Findings include: R5's Face Sheet undated, indicated R5 admitted to the facility on 7/16/21. R5's Care Plan revised 11/22/21, indicated R5 was considered a vulnerable adult due to his cognitive and functional deficits and was not to leave the facility without supervision from his	2 830		

Minnesota Department of Health

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2 830	Continued From page 4 guardians or aunt, and R5 refuses to comply with plan to not leave the facility unsupervised. (date initiated 8/17/21). R5's significant change Minimum Data Set (MDS) dated 1/7/22, indicated he was cognitively intact, had no behaviors and no wandering. R5's MDS further indicated he received antidepressant medications (used to address symptoms of depression), antipsychotic medications (used to manage psychosis, including delusions, hallucinations, paranoia or disordered thought) and hypnotic medications (produce sleep). R5's Wandering Risk Scale assessment dated 7/16/21, indicated R5 was dependent on activities of daily living (ADL)'s, and cannot move with out assistance and required assistance from staff for transfers and was independent with the use of an electric wheelchair. The assessment further indicated R5 was at low risk for wandering. R5's Risks vs Benefits assessment dated 8/17/21, recommended R5 would not leave facility unsupervised due to high risk for abuse by others and exploitation due to his cognition and quadriplegia diagnosis. In addition, the assessment indicated R5's guardian agreed with the plan not to allow R5 to leave the facility without supervision however, the guardian did express R5 "is going to do what [R5] wants to do." R5's Occupational Therapy assessment dated 10/5/21, indicated R5 had quadriplegia (paralysis of the arms and legs caused by neurological damage), alcohol addiction and abuse, nicotine dependence, depression and antisocial personality disorder (a mental disorder in which a person consistently shows no regard for right and	2 830			

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2 830	Continued From page 5 wrong and ignores the rights and feelings of others). The assessment further indicated R5 lacked capacity for chronic disease management and lacked insight into condition. R5's Medical History undated, indicated he was diagnosed with quadriplegia and a traumatic brain injury following a car accident and uses a mobilized wheelchair for mobility. Review of R5's progress notes indicated on 8/27/21, the facility received a phone call from St. Cloud police that R5 was found at a nearby gas station. R5's speech was mumbled and did not appear to be able to safely drive himself back to the facility in his motorized wheelchair. He was sent to the emergency room (ER) and treated for alcohol toxicity. During interview 1/13/22, at 4:05 p.m. assistant director of nursing (ADON) stated she had concerns with R5 leaving the facility and coming back smelling like marijuana along with his old roommate. The ADON stated he was hospitalized in the past for alcohol intoxication. The ADON stated he will make phone calls and go off the facility grounds to buy marijuana which they would then confiscate from him. During interview on 1/14/22, at 1:00 p.m. the director of nursing (DON) stated R5 had a motor vehicle accident in his teens and was diagnosed with a traumatic brain injury following the car accident and now used a motorized wheelchair for mobility. The DON stated she was unsure how he obtained the alcohol for his 8/27/21, ER visit. Further the DON stated R5 had made plans to go get medical marijuana that day (8/27) and his dad said he could not go, so the facility canceled his cab. The DON stated the facility was	2 830			

Minnesota Department of Health

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2 830	Continued From page 6 aware R5 was upset and took off (left campus unsupervised) but did not consider this an elopement. He was found later at the gas station very intoxicated by the police. During interview on 1/14/22, at 11:39 a.m. receptionist stated she was informed about 2 weeks ago that she could let R5 leave the building to smoke and was given no instruction to observe him. She stated she was unable to see him or keep him in her line of sight while he was outside. She does not keep track of how long he was outside or when/if he returns. During observation and interview on 1/14/22, at approximately 11:00 a.m. surveyor was informed R5 had left the facility and the DON had just called 911. Both surveyor and ADON went outside and found R5 driving down the middle of the road in his motorized wheelchair toward the facility during moderate snow fall, with difficult visibility. R5 was observed to be wearing just a sweatshirt and pants with footwear, no jacket or other outerwear. The temperature was 10 degrees. The facility was unsure what time R5 may have left the building that morning. -while outside looking for R5, the ADON pointed out a secured smoking area that was monitored by staff. Later at 3:30 p.m. the ADON was interviewed and asked why R5 does not use the secured smoking area, at which time the RN manager stated that R5 "does what he wants, when he wants." During interview on 1/14/22, at 2:10 p.m. the DON stated R5 had left the facility unsupervised at least 5 times since admission. The DON further indicated on multiple occasions he was found with marihuana they had to confiscate from	2 830			

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2 830	Continued From page 7 him. Record review of R5's drug screening indicated on 8/12/21, 8/27/21, and 12/28/21, R5 tested positive for tetrahydrocannabinol (THC). During interview on 1/14/22, at 2:53 p.m. nursing assistant (NA)-B stated R5 was allowed to go outside for about 10 minutes. She is not sure who monitors him, it would have to be the person who let him out. NA-B indicated she received training that R5 and his roommate could go outside but had to have coats on first. She was not aware they had to be supervised. Review of Realis computer training records indicated on 1/7/22, R5 and his roommate can go outside for 10 minutes if they put a coat on. Communication to employees lacked evidence R5 required supervision if leaving the facility as indicated in his Care Plan. During interview on 1/14/22, at 2:57 p.m. licensed practical nurse (LPN)-B stated R5 was allowed to leave the facility. In addition, LPN-B stated with his behavior changes they are reassessing if this should be allowed. LPN-B also stated that today he had an incident and they did not know where he was so they had to call 911. During interview on 1/14/22, at 3:04 p.m. ADON stated R5 was able to go outside for 10 minutes and could not leave the grounds, and needs supervision per his guardian. Furthermore the ADON stated she just had gotten off the phone with R5's dad minutes before this interview and stated his dad does not want him to be leaving the facility grounds because he engages in self destructive behavior such as heavy drinking, drugs, ect. and R5 is very difficult to work with. In	2 830		

Minnesota Department of Health

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2 830	Continued From page 8 addition, the ADON stated she had been instructed when R5 leaves the facility it was not considered an elopement since he had a destination he was going to. During interview at 1/14/22, at 3:30 p.m. the DON stated the facility does not have any formal plans for when R5 leaves the facility grounds to direct the staff what to do if they suspect he had been under the influence of alcohol or drugs. In addition the DON stated they were not following the care plan as stated and should have had a better system in place for staff to be monitoring when R5 was leaving and returning, including the staff at the front desk monitoring his exit. During interview 1/17/22, at 11:00 a.m. R5's guardian stated he does not want R5 to leave the facility grounds without supervision since he does not make safe decisions. The facility's Elopement Policy revised 9/2/21, indicated, "It is the policy of this facility that all residents are afforded adequate supervision to provide the safest environment possible. All residents will be assessed for behaviors or conditions that put them at risk for wandering/elopement. All residents identified will have these issues addressed in their individual care plan." The IJ which began on 8/27/21, was removed on 1/18/22 at 11:28 a.m., when the facility successfully implemented a removal plan which included reviewing the applicable policies and procedures, ensured all residents were reassessed and care planned for their elopement risks and needs, and ensured all facility tools (i.e. w binder) were updated with current, correct information to help staff ensure safety and	2 830		

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2 830	Continued From page 9 prevent elopements of residents identified to be at risk and those at risk are supervised. On 1/18/22, from approximately 9 a.m. to 11:00 a.m. direct care staff were interviewed and verified education had been completed and systems were in place to ensure residents were not at continued significant risk of elopement and those at risk are supervised but, non-compliance remained at an isolated pattern with potential for more than minimal harm which is not immediate jeopardy (Level D). SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper monitoring of medication usage to include side effects for medications. In addition the DON or designee will ensure ordered laboratory tests are completed per the physician order and timely. The DON or designee, along with the pharmacist, could audit medication reviews on a regular basis to ensure compliance. TIMEFRAME FOR CORRECTION: Twenty-one (21) days.	2 830		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced	2 920		2/11/22

Minnesota Department of Health

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2 920	Continued From page 10 by: Based on observation, interview, and document review, the facility failed to ensure assistance was provided with routine grooming and personal hygiene for 1 of 3 residents (R1) who was dependent on staff for grooming and nail care reviewed for activities of daily living (ADLs). Findings include: R1's discharge Minimum Data Set (MDS), dated 12/31/21, indicated R3 was cognitively intact. In addition, the MDS identified R1 required extensive assistance for personal hygiene which included combing hair, shaving, washing/drying of hands. R1's care plan dated 1/4/22, did not address R1's ADL function and required assistance with grooming. On 1/13/22, at 9:57 a.m. R1 was observed in his bed looked disheveled with long facial hair and fingernails. Underneath the fingernails was a large amount of dirt. Also R1 had multiple small scratches and scabs on his left forearm and elbow. On 1/13/22, at 11:22 a.m. interviewed R1's power of attorney (POA) who stated R1 was never groomed and had long facial hair and dirty long fingernails. The POA stated she brought a razor for staff to use but they were not using it and R1 appeared disheveled all the time. The POA further stated she did not like seeing R1 not well groomed. -At 12:10 p.m. the POA stated R1 had always been a "picker" ever since he was a child and gets scratches and scabs on his left arm frequently. POA then stated maybe R1 would not	2 920	Corrected.	

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 01/18/2022
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) COMPLETE DATE
2 920	Continued From page 11 have as many scratches and scabs if the fingernails were kept short. On 1/13/22, at 12:15 p.m. interviewed POA's fiancé who stated he had known R1 for a long time and when he and the POA visited R1 he always appeared disheveled with long head hair, facial hair and fingernails and R1 had always been a clean shaven person and well-kept prior to his admission to the facility. On 1/14/22, at 9:20 a.m. interviewed R1 who stated they had not cut his fingernails or facial hair. R1 appeared as he did on 1/13/22. R1 stated he had not gotten a shower in a long time, but staff did clean him up some with some towels while in his bed the previous day on 1/13/22. On 1/14/22, at 9:25 a.m. interviewed nursing assistant (NA)-A who stated R1 received his bath on 1/13/22, which was his bath day scheduled one time per week. NA-A stated she was not aware of any bathing concerns for R1. NA-A stated R1 was a full assist for most cares including grooming. On 1/14/22, at 10:09 a.m. interviewed licensed practical nurse (LPN)-A who stated R1 does refuse cares sometimes. She then stated how staff approached R1 was important for and she could typically convince R1 to allow cares. LPN-A further stated R1 had been allowing bed baths and R1 required full assist for ADLs and grooming. On 1/14/22, at 12:20 p.m. interviewed the director of nurse (DON) who stated she was unaware of concerns with R1's grooming. The DON stated grooming should be done with his weekly bathing. The DON acknowledged R1's care plan was	2 920		

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2 920	Continued From page 12 incomplete and had not been properly updated after the recent re-admission to the facility on 1/3/22. DON acknowledged R1's long fingernails were contributing to the left arm scratches and scabs. The DON further stated staff should be making sure R1's grooming got done. The facility Policy and Procedure Activities of Daily Living, dated 3/15/21, indicated the facility will provide a comprehensive assessment of a residents to identify needs and choices. In addition, the policy indicated the facility will provide care and services for the following ADLs: hygiene, mobility, elimination, dining and communication. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could educate responsible staff to provide care to residents' dependant on facility staff, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of dependent resident cares to ensure their personal hygiene needs are met consistently. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced	21805		2/11/22

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21805	Continued From page 13 by: Based on interview and record review the facility failed to ensure assistance with cares were completed to maintain dignity for 1 of 1 residents (R5) who required staff assistance with cares. Findings include: R5's significant change Minimum Data Set (MDS) dated 1/7/22, indicated he was cognitively intact, had no behaviors, no wandering, required extensive assist of two with bed mobility, transfers and toileting and assist of one with personal hygiene and eating. R5's care plan dated 12/28/21, indicated for activities of daily living (ADL)'s R5 had impaired balance, limited mobility and was a quadriplegic (paralysis of the arms and legs caused by neurological damage). In addition R5's care plan indicated he required extensive assistance with personal hygiene. R5's Occupational Therapy assessment dated. 10/5/21, indicated R5 had quadriplegia, alcohol addiction and abuse, nicotine dependence, depression and anti-social personality disorder (a mental disorder in which a person consistently shows no regard for right and wrong and ignores the rights and feelings of others). The assessment further indicated R5 lacked capacity for chronic disease management and lacked insight into condition. During observation 1/13/22, at 10:14 a.m. R5 was observed from his room lying in bed next to the window from the hallway with no clothing from the waist down he was yelling "Can I get up! Will someone help me!" Surveyor entered room and R5 was observed to be unclothed from the waist	21805	Corrected.	

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21805	Continued From page 14 down. R5's genitalia was observed and colostomy bag. Surveyor left room as R5 stated he wanted to talk later after he was up in his wheelchair. Approximately three minutes later while R5 was still yelling, licensed practical nurse (LPN)-A was observed to walk into the room and talk to R5 for 20 seconds and left R5's room without covering R5 and leaving R5's room with his door open the entire time. Approximately two minutes later LPN-A returned to move R5's wheelchair and housekeeping arrived to mop his floor due to pop which was spilled on his floor. During the entire observation R5's door was never shut and R5 was never covered for privacy. During interview 1/13/22, at 3:00 p.m. R5 stated he had just moved into his room and was not aware anyone could see him from the door and if he knew staff or visitors could see him it would definitely bother him. In addition R5 stated "I think sometimes the staff just forget to shut the door or cover me up but it does upset me". During interview 1/18/22, at 9:30 a.m. LPN-A stated she was caring for R5 on 1/13/22, and was in and out of the room in the morning and remembered not shutting the door and really did not notice R5 was uncovered and if she did she should have covered R5 up or shut the door for dignity purposes. LPN-A stated she should look closer at the residents when she enters the room to make sure they are fully covered. Facility policy Privacy and Dignity dated 1/10/22, indicated "Privacy is provided during cares and resident is appropriately covered" SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could review/revise policies on dignity and educate all	21805			

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21805	Continued From page 15 staff on those policies. The DON and/or designee could conduct audits of resident cares to ensure residents with exposed body parts, are offered and assisted to appropriately cover their exposed skin and to ensure personal hygiene is maintained. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21805			