DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 9, 2022

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

RE: CCN: 245438
Cycle Start Date: March 18, 2022

Dear Administrator:

On April 5, 2022, we notified you a remedy was imposed. On April 27, 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 April 27, 2022.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective June 28, 2022 did not go into effect. (42 CFR 488.417 (b))

In our letter of March 31, 2022, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 18, 2022 due to denial of payment for new admissions. Since your facility attained substantial compliance on April 27, 2022, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Electronically Submitted
April 5, 2022

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

RE: CCN: 245438
Cycle Start Date: March 28, 2022

Dear Administrator:

On March 18, 2022, survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J). Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

In addition, this survey also 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), whereby corrections are required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On March 15, 2022, the situation of immediate jeopardy to potential health and safety cited at F689 was removed.

REMEDIES

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

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective June 28,

2022, (42 CFR 488.417 (b)).

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

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective June 28, 2022, (42 CFR 488.417 (b)), (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective, June 28, 2022, (42 CFR 488.417 (b)).

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective March 18, 2022. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require 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 Sections 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 March 18, 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.

DEPARTMENT CONTACT

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

Judy Loecken, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 28, 2022 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS DENIAL OF PAYMENT

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

Tamika.Brown@cms.hhs.gov

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

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

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

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

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

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

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

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

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

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245438	A. BUILDING _____ B. WING _____	C 03/18/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

On March 17-18, 2022, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance.

The following complaint was SUBSTANTIATED: H5438159C (MN81681) and cited at F689 for PAST NON-COMPLIANCE.

Although the provider had implemented corrective action prior to survey, immediate jeopardy was sustained prior to the correction. NO plan of correction is required for a finding of past non-compliance. The facility is still required to acknowledge receipt of the electronic documents.

The following complaint was SUBSTANTIATED: H5438160C (MN81729) and cited at F626.

The following complaints were found to be UNSUBSTANTIATED: H5438158C (MN81388), H5438161C (MN81733).

The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.

Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/08/2022

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 000	Continued From page 1 regulations has been attained.	F 000		
F 626 SS=D	Permitting Residents to Return to Facility CFR(s): 483.15(e)(1)(2) §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first	F 626		4/22/22

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F 626	Continued From page 2 availability of a bed there. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to allow 1 of 1 resident (R1) reviewed for involuntary discharge to return to facility following hospitalization. Findings include: R1's admission record indicated R1 was admitted 5/19/21. R1 was his own responsible person. R1 diagnosis included chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD-a chronic inflammatory lung disease that causes obstructed airflow from the lungs), alcoholic cirrhosis of liver, CVA (cerebral vascular accident) and diabetes mellitus. R1's quarterly Minimum Data Set (MDS) dated 12/23/21, indicated R1 was cognitively intact. R1 required extensive assistance with bed mobility, dressing, toileting, and personal hygiene. R1's care plan indicated R1 wished to remain at the facility for long term care. R1's pulmonology clinic consult dated 8/20/21, indicated continuous oxygen at three liters per minute (LPM). Provider note dated 1/10/21, identified R1's smell of "marijuana" which suggested either strong or heavy use, and therefore no drug screen was necessary. An untitled document dated 1/17/22, indicated R1 was provided education on illegal substance use and storage in the facility being prohibited. R1	F 626	F626: Permitting Residents to Return to Facility " Resident (R1) was returned to the facility on 3/30/2022. Resident issued a 30-day notice for discharge on 3/29/2022 and resident (R1) agreed and was discharged to another facility on 4/5/2022. " No other like residents identified per review of transfers/discharges in the past three months. " Education provided to Director of Nursing, Assistant Director of Nursing, Nurse Manager, and Social Worker on the Admission, Readmission, Bed Hold, and Transfer/Discharge Policy and Procedure. " Weekly audits will be completed by the Director of Social Services or designee to validate that residents who transfer to the hospital are provided the opportunity to return to the facility for 1 month. " Audit results to be reviewed at monthly QAPI to evaluate the effectiveness of resident determination adherence and the need for audit continuation. " Director of Social Services or designee responsible for ensuring compliance.	

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F 626	Continued From page 3	F 626		

agreed to abstain from illegal substance use and storage in the facility and expressed an understanding of the information. R1 signed the untitled document.

A progress note dated 3/8/22, at 4:23 p.m. indicated R1 was smoking in his room while wearing his oxygen and started a fire to his nasal, upper lip area and hands. EMS (emergency medical services) was called and R1 was transported to the hospital for evaluation.

A progress note dated 3/9/22, indicated R1 was presented with a written 30-Day Discharge Notice in person by facility staff while he was in the hospital. The hospital social worker was present, and a copy was given to R1 and the social worker. R1 stated he wanted to appeal the discharge. The 30-day discharge indicated the anticipated date of discharge was immediate, up to but no later than April 9, 2022.

A Thirty Day Discharge Notice dated 3/9/22, was due to unsafe practices of smoking in his room while using oxygen. It further indicated, R1 was a risk to other residents with his drug addiction and unwillingness to follow safety protocols. It also revealed, R1 was not safe even if the facility provided one to ones.

During an interview on 3/17/22, at 12:25 p.m. the director of nursing (DON) stated R1 lacked compliance with having illegal substances in the building. On 3/18/22, the DON stated, in the past, R1 had no consequences given to him when found smoking or suspected of smoking illegal substance in the facility.

During an interview on 3/18/22, at 11:17 a.m. the

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F 626	Continued From page 4	F 626		

long-term care Ombudsman (LTCO-A) stated R1 was not given an appropriate 30-day discharge. LTCO-A stated the facility was encouraged to readmit R1 for the remaining part of the 30 days. However, the facility failed to comply.

During an interview on 3/18/22, at 12:06 p.m. the administrator stated R1 was his own person. The administrator stated R1 was not given any written consequences for previous smoking or suspected smoking of illegal substances. The administrator stated the 30-day discharge notice was given to R1 for lighting himself on fire in his room. The facility had a sprinkler system for fires in the building. The administrator was not aware whether or not R1 had smoked while wearing oxygen before. She stated the company told her to not take R1 back and work with the SCH to find the correct location for him.

During an interview on 3/21/22, the hospital licensed social worker (LSW)-A stated R1 was medically ready for discharge from the hospital the week of 3/14-18/22, and the facility declined to allow R1 to return.

The facility policy Admission, Readmission, Bed Hold, and Transfer/Discharge dated 10/12/21, indicated the facility must permit each resident to remain in the facility, and not transfer or discharge the resident unless, the transfer or discharge is necessary for the residents' welfare and the resident's needs cannot be met in the facility. The transfer or discharge is appropriate because the resident's health has improved sufficiently, and the resident no longer needs the services provided by the facility. The safety of the individuals in the facility is endangered due to the clinical or behavioral status of the resident. The

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F 626	Continued From page 5 health of individuals in the facility would otherwise be endangered.	F 626		
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 interview and document review the facility failed to ensure 1 of 1 resident (R1) was appropriately supervised and prohibited from keeping a cigarette lighter and smoking material in his room. R1 was smoking with oxygen on while in his room which resulted in burns to his face. The deficiency was identified as past non compliance and issued at Immediate Jeopardy (IJ). The IJ began on 3/8/22, at 4:25 p.m. when R1 received burns to his face while smoking and wearing oxygen. However, the facility immediately implemented corrective action to prevent reoccurrence by 3/15/22 before survey started. The administrator and director of nursing (DON) were notified of the IJ past noncompliance on 3/17/22 at 5:25 p.m. as a result of corrective action taken by the facility. Findings include: R1's admission record indicated R1 was admitted	F 689	Past noncompliance: no plan of correction required.	4/8/22

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	245438	A. BUILDING _____ B. WING _____	C 03/18/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 6	F 689		

5/19/21. R1 was his own responsible person. R1 diagnosis included chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD-a chronic inflammatory lung disease that causes obstructed airflow from the lungs).

R1's quarterly Minimum Data Set (MDS) dated 12/23/21, indicated R1 was cognitively intact. R1 required extensive assistance with bed mobility, dressing, toileting, and personal hygiene. The MDS did not identify R1 smoked.

R1's care plan dated 6/2/21, lacked any indication R1 smoked cigarettes or used illegal substances. There was no indication in the medical record the faciltiy assessed R1's smoking safety.

R1's pulmonology clinic consult dated 8/20/21, indicated R1 had smoked four packs of cigarettes a day for 48 years and had a history of using illegal drug. R1 used continuous oxygen at three liters per minute (LPM).

Progress notes revealed the following:
-10/24/21, registered nurse (RN)-A documented R1's room smelled of smoke and R1 was told to not smoke in the room due to high risk of causing fire because R1 was on continuous oxygen.
-10/28/21, director of nursing (DON) documented smell of smoke coming from R1's room. R1 denied smoking.
-11/12/21, licensed practical nurse (LPN)-C documented R1 was found smoking.
-1/16/22, RN-B documented R1 was observed smoking by the chapel door. She searched R1's room and notified the DON.
-1/30/22, LPN-B documented R1 was observed smoking in the corner on the fireside area of facility, DON notified.

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F 689	Continued From page 7 -2/22/22, LPN-A documented staff smelled smoke coming from R1's room, staff took contraband and educated on facility smoking policies. -2/22/22, LPN-B documented entry into R1's room and observation of R1 lighting smoking material. She contacted the DON, searched the room and R1 was yelling "I will smoke whenever I feel like it" and refused to give LPN-B the contraband. -3/1/22, the administrator documented R1's room smelled of smoke he was informed resident rooms were not authorized smoking areas. -3/8/22, RN-C documented approximately at 4:20 p.m. R1 had lit his oxygen on fire attempting to smoke in his room. Emergency medical services (EMS) were called to transport to the hospital. When RN-C asked him what happened R1 stated nothing. R1's face was black, the air smelled of burnt hair and flesh. A lighter was found on the bedside table. R1's nasal cannula was destroyed. EMS arrived and took R1 to the hospital for evaluation. R1's room was searched and the contraband was given to the administrator. Provider note dated 1/10/21, identified R1's smelled of "marijuana" which suggested either strong or heavy use, and therefore no drug screen was necessary. An untitled document dated 1/17/22, indicated R1 was provided education on illegal substance use and storage in the facility was prohibited. R1 agreed to abstain from illegal substance use and storage in the facility while he resided. He expressed an understanding of the information and signed the document.	F 689		

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F 689	Continued From page 8 During an interview on 3/17/22, at 11:53 a.m. licensed practical nurse (LPN)-A stated she had found R1 in his room on 2/22/22, with a pipe and lighter in his hands. LPN-A informed R1 he could not smoke in the facility. LPN-A searched R1's room, confiscated and removed the contraband. LPN-A told R1 that he could blow himself and others up if R1 kept smoking with his oxygen on. LPN-A stated she had informed the director of nursing (DON) what had occurred. LPN-A stated she had caught R1 smoking a few times before this. However, LPN-A could not recall if his oxygen was on. During an interview on 3/17/22, at 12:25 p.m. the DON stated R1 lacked compliance with having smoking substances in the building. On 3/18/22, the DON stated R1 had no consequences given to him when found smoking or suspected of smoking in the facility in January 2022. The DON stated she did not know that R1 smoked anything, however she suspected. The DON stated there was no smoking assessment completed for R1. They should have completed a smoking assessment when they became aware of R1 smoking in January 2022. LPN-B stated on 3/8/22, at 4:30 p.m. she heard R1 calling out and found from him in his room calling out "oh boy" several times and the room smelt of burnt flesh. R1 was putting out flames on his upper chest, beard area, nose, lips, left arm and hand. R1's had black soot on his face and chest area. LPN-B helped to smother out the flames. The oxygen concentrator was on in the room and LPN-B shut it off and removed the oxygen concentrator out of R1's room. LPN-B stated the oxygen nasal cannula tubing had been burnt and was in two pieces, it had not burned to	F 689		

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F 689	Continued From page 9	F 689		

R1's face but came off easily. The smoking contraband was confiscated. LPN-B stated she did not see R1 smoking but smelled it in the room.

During an interview on 3/18/22, at 12:06 p.m. the administrator stated R1 was his own person. R1 had signed a contract but was never given any written consequences for previous smoking infringements. The administrator stated this was the first time R1 had lit himself on fire with the oxygen on. The administrator was not aware that R1 had smoked with the oxygen on before this event.

The facility policy Smoking ad E-Cigarettes dated 3/1/21, revealed smoking was only permitted in posted designated areas. No oxygen containers/tanks/materials or other flammable substances are permitted in the designated smoking area. It further indicated, smoking will only be permitted by residents after safety assessment by the interdisciplinary team.

The past non-compliance that began on 3/8/22, was verified during the 3/17/22, in the afternoon and identified the immediacy was corrected on 3/15/22.

During an interview on 3/17/22, at 12:25 p.m. the DON stated the facility had reviewed all care plans and updated with smoking assessments, risk verses benefits, illegal substances contracts, and acknowledgement of smoking policy. Further, if smoking substances were found, a room search would be ordered and put on the treatment administration record (TAR). All residents on oxygen had signs put on their doors. The facility had a Safety Council meeting,

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F 689	Continued From page 10 updated the contraband, smoking, and oxygen use policies, conducted a facility wide smoking education and a mock fire drill. Audit of resident documents verified smoking assessments were completed and care plans were updated on 3/9/22. Documented notes verified a Safety Council Meeting and fire drill on 3/9/22. Staff interviews on 3/17/22, confirmed training had been completed and were aware of smoking policy, and the reporting of smoking concerns. Staff interviews indicated staff were aware of R1's smoking restrictions. Other documentation provided, revealed that as of 3/15/22, the facility had over 90% of staff re-educated on Improper/Unsafe Resident Smoking and the Prohibition of Illegal/Illicit Materials in the facility. Facility conducted audits on resident smoking safely.	F 689		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 5, 2022

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

Re: Event ID: WJHQ11

Dear Administrator:

The above facility survey was completed on March 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,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00614	A. BUILDING: _____ B. WING _____	C 03/18/2022

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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 March 17-18, 2022, 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		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5438159C (MN81681) and H5438160C (MN81729), however, NO licensing orders were issued. The following complaint was found to be UNSUBSTANTIATED: H5438158C (MN81388) and H5438161C (MN81733). 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 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	2 000		

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2 000	Continued From page 2 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		