



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 6, 2022

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

Re: Reinspection Results
Event ID: PXZN12

Dear Administrator:

On June 27, 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 June 20, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
June 6, 2022

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

RE: CCN: 245438
Cycle Start Date: May 13, 2022

Dear Administrator:

On May 20, 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) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On May 20, 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.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective June 21, 2022.

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 21, 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 21, 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 May 20, 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 May 20, 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 August 13, 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/ltr_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable 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, 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

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

PRINTED: 06/15/2022
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 05/20/2022
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 On 5/18 to 5/20/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The survey resulted in an Immediate Jeopardy (IJ) at F689 when the facility failed to provide adequate supervision to prevent accidents. The IJ began on 5/18/22, and the immediacy was removed on 5/20/22. The above findings constituted substandard quality of care, and an extended survey was conducted 5/20/22. The following complaint was found to be SUBSTANTIATED: H54381742C (MN83564), with a deficiency cited at F689. The following complaints were found to be UNSUBSTANTIATED: H5438169C (MN82368/MN82374), and H5438168C (MN82481) 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	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/09/2022

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	F 000			
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify possible elopement behaviors and develop interventions for 1 of 1 residents (R1) who was cognitively impaired, wandered and left the building without staff knowledge. This resulted in an Immediate Jeopardy (IJ). The IJ began on 5/13/22, when R1 left the building without staff knowledge and was found at the bottom of a steep hill, near a busy street. The administrator and director of nursing (DON) were notified of the IJ on 5/19/22, at 6:50 p.m. The immediate jeopardy was removed on 5/20/22, at 4:26 p.m. and the non-compliance remained at the lower scope and severity of a D, no actual harm with a potential for more than minimal harm. Findings include: R1's significant change Minimum Data Set (MDS), dated 3/9/22, indicated R1 had severe cognitive impairment, non-traumatic brain dysfunction, traumatic brain injury (TBI), and no	F 689	R1: Elopement Risk Assessments created and completed on 5/19/2022. New interventions to include: - o Staff to provide 1:1 supervision when resident requests to sit outside. Nursing order added to monitor resident behavior regarding wandering and exit seeking behaviors to be continued until the weather starts to drop in temperature. - o The resident's trigger for wandering is warm weather. The resident's behavior is deescalated by staff assisting and supervising resident outside. " All residents with a BIMS of 7 or lower have the potential to be affected. " Residents with a BIMS of 7 or lower had new Elopement Risk Assessments completed. Any needed additions to the care plans have been completed. " Licensed staff educated on the Elopement Risk Assessment. " Staff education on the Elopement Policy and the resetting of the mag lock on the door.		6/16/22

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F 689	Continued From page 2 wandering behaviors. Additionally, R1 needed supervision with locomotion on and off the unit, was not steady walking, needed a walker, and had two or more falls since prior assessment. R1's care plan printed 5/18/22, identified R1; had limited physical mobility related to dementia, impaired cognitive function related to history of head injury (resident required cues and reminders for Activities of daily living), unsteady gait/balance, high risk for falls, impaired visual function, poor decision making, and exhibited delusions about her husband that was deceased. There was no indication R1 was at risk for wandering. A progress note dated 5/8/22, at 12:03 p.m. stated R1 ambulated around the building as she looked for her mother and father-in-law, (who were deceased), and at 9:08 p.m. R1 wandered the building as she searched for Santa Claus, and "wanted to go to Melrose" to see her husband. A progress note dated 5/13/22, at 11:08 p.m. RN-A documented at approximately 8:00 p.m. nursing assistant (NA)-C was unable to find R1. RN-A went to foyer, where she had seen R1 earlier, and noted the front maglock system was disarmed. R1 was found outside standing at the bottom of a the hill with her walker. R1 told staff she went outside to get some "fresh air". Although progress notes of 5/8/22 identified R1 was wandering around the building, and left the building without staff knowledge on 5/13/22, the facility had not completed a wander risk assessment until after the 5/13/22 event.	F 689	" Weekly audits to be completed x 4 weeks to validate that residents at risk for elopement are in the Elopement Binder and their care plan interventions are in place and being followed. " Audit results to be reviewed at monthly QAPI to evaluate the effectiveness of the plan of correction and to determine need for audit continuation. " NHA/Designee is responsible for ensuring compliance.		

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F 689	Continued From page 3 R1's Wander Risk Scale assessment, dated 5/13/22, identified risk factors included history of wandering, mental status, diagnosis, and mobility. The assessment indicated R1 "has no reported episodes of wandering in past 6 months" and "no diagnosis of dementia"; which resulted in a score of 4 (a score chart indicated "0-8 Low Risk"). The assessment, indicated R1 was not at risk and did not need a new care plan or interventions even though the progress notes identified R1's wandering behavior. On 5/14/22 R1's care plan indicated R1 left the facility on 5/13/22. Interventions were initiated for 15-minute checks, monitor resident for "tailgating" (follow close behind) when visitors are in the building, and wander risk assessment per facility policy. R1's care plan was updated on 5/18/22 and identified R1 was safe and removed 15-minute check intervention. Although the facility removed the 15-minute checks, they did not implement any interventions to prevent R1 from going outside unsupervised, even though she continued to have wandering behaviors. Review of facility's investigation as of 5/18/22, indicated video footage was reviewed and it "appeared" NA-B may have disarmed the door at 6:30 p.m. R1 was sitting in the lobby area then seen going out the front door and was outside for 10 minutes before staff assisted her back in the facility. NA-B was re-educated on the importance of making sure the door is armed for alarm. On 5/18/22, at 2:09 p.m. RN-A stated she had been alerted by NA-C on 5/13/22, at approximately 8:00 p.m. that he could not locate R1. RN-A had seen R1 less than 20 minutes earlier sitting in the foyer of the facility. She	F 689			

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F 689	Continued From page 4 noticed the front door was disarmed, so she walked out of the building, and saw R1 at the bottom of the hill with her walker. RN-A stated R1's had impaired cognition and "she [R1] is not somebody I would be willing to just send outside on her own." On 5/18/22, at 3:27 p.m. interim director of nursing (DON) stated the entry door had a maglock system and was kept locked to make sure people that entered the facility were screened for COVID-19, not to keep any residents from getting out of the facility. DON stated she had not yet completed the investigation, but video from 5/13/22, revealed R1 did not leave facility grounds. Therefore, the incident was not an elopement. The facility grounds where R1 ambulated down the hill in her walker was observed on 5/19/22, at 9:20 a.m. was steep and adjacent to a busy city street that had 2 apartment complexes on one side and the facility on the other side of the street. On 5/19/22, at 10:32 a.m. nursing assistant (NA)-A stated the facility kept an Elopement Book at the front desk with photos of residents at risk for elopement. NA-A further stated that she knows R1's abilities and even though it was not on R1's plan of care (POC), R1 would need to be supervised or she could wander outside the facility. On 5/19/22, at 10:46 a.m. NA-B stated that after the incident, she was educated to make sure the door was locked every time the alarm was turned off. NA-B further stated R1 wandered in the building but could not go outside without supervision because of R1's impaired cognition.	F 689			

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F 689	Continued From page 5 On 5/19/22, at 2:05 p.m. assistant director of nursing (ADON) stated after R1 was found outside without supervision, 15-minute checks were initiated, but had been discontinued on 5/18/22. ADON stated after the incident, "a history of wandering" should have been identified on the updated wandering risk assessment. She stated, R1 was not safe to go outside without supervision due to her impaired cognition and mobility. On 5/19/22, at 3:29 p.m. DON stated R1 had a purpose and was "very clear" about her purpose to go outside. Therefore, she would not call it wandering, and R1's care plan had not been updated to have her supervised when outside. DON acknowledged she did not ask direct care staff about supervision of R1. Further, she was not aware if family had been contacted. DON stated Wandering Risk assessments were completed on 5/13/22, and 5/18/22, and R1 was a low risk for wandering/eloping. DON stated, "I consider her to be safe to be outside unsupervised". On 5/19/22, at 4:22 p.m. Regional Director of Clinical Services (RN)-B stated going outside with the intent to get fresh air would not be wandering. It was a purposeful choice. RN-B clarified "you can be high risk, but not necessarily an elopement risk". RN-B stated it was case-by-case, provider and family directed. Further, RN-B stated her expectation was staff would follow the process which was to notify provider and family. Additionally, RN-B stated she "would expect the front-line staff would be asked for their observations and comments" when determining resident safety to be outside	F 689			

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

PRINTED: 06/15/2022
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 05/20/2022
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 6 unsupervised. R1's physician progress notes, dated 5/26/21, 11/11/21, 3/7/22, 5/12/22, all indicated R1's diagnoses included dementia with moderate-advanced impairment level. The facility's Elopement Risk and Prevention Policy, revised 9/2/21, indicated all residents were afforded adequate supervision to provide the safest environment possible, and "all residents will be assessed for behaviors or conditions that put them at risk for wandering/elopement". The policy defines wandering as "random or repetitive locomotion" that "may be goal-directed, or non-goal-directed or aimless". The immediate jeopardy began on 5/13/22, when R1 was unsupervised when exiting the building. The immediacy was removed 5/20/22, at 4:26 p.m. Audit of facility documents verified the facility updated the elopement risk and prevention policy, created a new elopement risk assessment, and conducted facility-wide elopement and maglock system education. Staff interviews on 5/20/22, confirmed training had been completed regarding updated elopement policy, and R1's wandering/elopement risk interventions. Audit of R1's documents verified a new elopement risk assessment was completed and care plan was updated on 5/19/22. R1's photo and wandering interventions were placed in the "Elopement Book".	F 689			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 6, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: PXZN11

Dear Administrator:

The above facility was surveyed on May 18, 2022 through May 20, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

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

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

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

Please feel free to call me with any questions.

Sincerely,

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

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

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 05/20/2022
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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 5/18 to 5/20/22, 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. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000			

Minnesota Department of Health

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

Electronically Signed

TITLE

(X6) DATE

06/09/22

Minnesota Department of Health

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H54381742C (MN83564), with a licensing order issued at S830. The following complaints were found to be UNSUBSTANTIATED: H5438169C (MN82368/MN82374), and H5438168C (MN82481). 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		
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 identify possible elopement behaviors and develop interventions for 1 of 1 residents (R1) who was cognitively impaired, wandered and left the building without staff knowledge. This resulted in an Immediate Jeopardy (IJ).	2 830	Corrected	6/16/22

Minnesota Department of Health

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2 830	Continued From page 3 The IJ began on 5/13/22, when R1 left the building without staff knowledge and was found at the bottom of a steep hill, near a busy street. The administrator and director of nursing (DON) were notified of the IJ on 5/19/22, at 6:50 p.m. The immediate jeopardy was removed on 5/20/22, at 4:26 p.m. and the non-compliance remained at the lower scope and severity of a D, no actual harm with a potential for more than minimal harm. Findings include: R1's significant change Minimum Data Set (MDS), dated 3/9/22, indicated R1 had severe cognitive impairment, non-traumatic brain dysfunction, traumatic brain injury (TBI), and no wandering behaviors. Additionally, R1 needed supervision with locomotion on and off the unit, was not steady walking, needed a walker, and had two or more falls since prior assessment. R1's care plan printed 5/18/22, identified R1; had limited physical mobility related to dementia, impaired cognitive function related to history of head injury (resident required cues and reminders for Activities of daily living), unsteady gait/balance, high risk for falls, impaired visual function, poor decision making, and exhibited delusions about her husband that was deceased. There was no indication R1 was at risk for wandering. A progress note dated 5/8/22, at 12:03 p.m. stated R1 ambulated around the building as she looked for her mother and father-in-law, (who were deceased), and at 9:08 p.m. R1 wandered the building as she searched for Santa Claus, and "wanted to go to Melrose" to see her husband.	2 830			

Minnesota Department of Health

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2 830	Continued From page 4 A progress note dated 5/13/22, at 11:08 p.m. RN-A documented at approximately 8:00 p.m. nursing assistant (NA)-C was unable to find R1. RN-A went to foyer, where she had seen R1 earlier, and noted the front maglock system was disarmed. R1 was found outside standing at the bottom of a the hill with her walker. R1 told staff she went outside to get some "fresh air". Although progress notes of 5/8/22 identified R1 was wandering around the building, and left the building without staff knowledge on 5/13/22, the facility had not completed a wander risk assessment until after the 5/13/22 event. R1's Wander Risk Scale assessment, dated 5/13/22, identified risk factors included history of wandering, mental status, diagnosis, and mobility. The assessment indicated R1 "has no reported episodes of wandering in past 6 months" and "no diagnosis of dementia"; which resulted in a score of 4 (a score chart indicated "0-8 Low Risk"). The assessment, indicated R1 was not at risk and did not need a new care plan or interventions even though the progress notes identified R1's wandering behavior. On 5/14/22 R1's care plan indicated R1 left the facility on 5/13/22. Interventions were initiated for 15-minute checks, monitor resident for "tailgating" (follow close behind) when visitors are in the building, and wander risk assessment per facility policy. R1's care plan was updated on 5/18/22 and identified R1 was safe and removed 15-minute check intervention. Although the facility removed the 15-minute checks, they did not implement any interventions to prevent R1 from going outside unsupervised, even though she continued to have wandering behaviors.	2 830			

Minnesota Department of Health

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2 830	Continued From page 5 Review of facility's investigation as of 5/18/22, indicated video footage was reviewed and it "appeared" NA-B may have disarmed the door at 6:30 p.m. R1 was sitting in the lobby area then seen going out the front door and was outside for 10 minutes before staff assisted her back in the facility. NA-B was re-educated on the importance of making sure the door is armed for alarm. On 5/18/22, at 2:09 p.m. RN-A stated she had been alerted by NA-C on 5/13/22, at approximately 8:00 p.m. that he could not locate R1. RN-A had seen R1 less than 20 minutes earlier sitting in the foyer of the facility. She noticed the front door was disarmed, so she walked out of the building, and saw R1 at the bottom of the hill with her walker. RN-A stated R1's had impaired cognition and "she [R1] is not somebody I would be willing to just send outside on her own." On 5/18/22, at 3:27 p.m. interim director of nursing (DON) stated the entry door had a maglock system and was kept locked to make sure people that entered the facility were screened for COVID-19, not to keep any residents from getting out of the facility. DON stated she had not yet completed the investigation, but video from 5/13/22, revealed R1 did not leave facility grounds. Therefore, the incident was not an elopement. The facility grounds where R1 ambulated down the hill in her walker was observed on 5/19/22, at 9:20 a.m. was steep and adjacent to a busy city street that had 2 apartment complexes on one side and the facility on the other side of the street. On 5/19/22, at 10:32 a.m. nursing assistant (NA)-A stated the facility kept an Elopement Book	2 830			

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2 830	Continued From page 6 at the front desk with photos of residents at risk for elopement. NA-A further stated that she knows R1's abilities and even though it was not on R1's plan of care (POC), R1 would need to be supervised or she could wander outside the facility. On 5/19/22, at 10:46 a.m. NA-B stated that after the incident, she was educated to make sure the door was locked every time the alarm was turned off. NA-B further stated R1 wandered in the building but could not go outside without supervision because of R1's impaired cognition. On 5/19/22, at 2:05 p.m. assistant director of nursing (ADON) stated after R1 was found outside without supervision, 15-minute checks were initiated, but had been discontinued on 5/18/22. ADON stated after the incident, "a history of wandering" should have been identified on the updated wandering risk assessment. She stated, R1 was not safe to go outside without supervision due to her impaired cognition and mobility. On 5/19/22, at 3:29 p.m. DON stated R1 had a purpose and was "very clear" about her purpose to go outside. Therefore, she would not call it wandering, and R1's care plan had not been updated to have her supervised when outside. DON acknowledged she did not ask direct care staff about supervision of R1. Further, she was not aware if family had been contacted. DON stated Wandering Risk assessments were completed on 5/13/22, and 5/18/22, and R1 was a low risk for wandering/elopeing. DON stated, "I consider her to be safe to be outside unsupervised". On 5/19/22, at 4:22 p.m. Regional Director of	2 830			

Minnesota Department of Health

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2 830	Continued From page 7 Clinical Services (RN)-B stated going outside with the intent to get fresh air would not be wandering. It was a purposeful choice. RN-B clarified "you can be high risk, but not necessarily an elopement risk". RN-B stated it was case-by-case, provider and family directed. Further, RN-B stated her expectation was staff would follow the process which was to notify provider and family. Additionally, RN-B stated she "would expect the front-line staff would be asked for their observations and comments" when determining resident safety to be outside unsupervised. R1's physician progress notes, dated 5/26/21, 11/11/21, 3/7/22, 5/12/22, all indicated R1's diagnoses included dementia with moderate-advanced impairment level. The facility's Elopement Risk and Prevention Policy, revised 9/2/21, indicated all residents were afforded adequate supervision to provide the safest environment possible, and "all residents will be assessed for behaviors or conditions that put them at risk for wandering/elopement". The policy defines wandering as "random or repetitive locomotion" that "may be goal-directed, or non-goal-directed or aimless". The immediate jeopardy began on 5/13/22, when R1 was unsupervised when exiting the building. The immediacy was removed 5/20/22, at 4:26 p.m. Audit of facility documents verified the facility updated the elopement risk and prevention policy, created a new elopement risk assessment, and conducted facility-wide elopement and maglock system education. Staff interviews on 5/20/22, confirmed training had been completed regarding	2 830		

Minnesota Department of Health

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2 830	Continued From page 8 updated elopement policy, and R1's wandering/elopement risk interventions. Audit of R1's documents verified a new elopement risk assessment was completed and care plan was updated on 5/19/22. R1's photo and wandering interventions were placed in the "Elopement Book". SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830			