



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

Dear Administrator:

On June 15, 2022, we notified you a remedy was imposed. On June 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 June 18, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective June 21, 2022 did not go into effect. (42 CFR 488.417 (b))

However, as we notified you in our letter of May 24, 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 is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 20, 2022. 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,

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



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July 6, 2022

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

Re: Reinspection Results
Event ID: 0CJ712

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 1, 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



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June 15, 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 24, 2022, we informed you that we may impose enforcement remedies.

On June 1, 2022, the Minnesota Department(s) of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

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

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

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. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 21, 2022.

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

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

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

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

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

DEPARTMENT CONTACT

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

**Susie Haben, Rapid Response
Licensing and Certification Program**

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

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

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

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

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

Talahi Nursing And Rehab Center

June 15, 2022

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

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

PRINTED: 06/22/2022
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 06/01/2022	
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 6/1/22, 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 following complaints were found to be SUBSTANTIATED: H54381908C/MN83843, with NO deficiencies cited. However, as a result of the investigation, deficiencies were cited at F604. 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 regulations has been attained.			F 000			
F 604 SS=E	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).			F 604			6/16/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/15/2022

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 604	Continued From page 1 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 2 of 2 residents (R1 and R2) were free from physical restraint when being locked within the facility with out medical cause. This had the potential to affect all residents locked in the facility not medical assessed to require such restriction. Findings include: R1's quarterly minimum data set (MDS) dated 2/26/22, indicated R1 was cognitively intact, had no wandering behavior, independent with mobility, impairment on one side of lower extremity and used a walker.	F 604	- Resident R1 and R2 are aware of the change in process listed below to allow their independence entering and exiting the building. - The front door will be unlocked/disarmed during business hours. After business hours, the door will be locked and alarmed. The code will be the month and year, two digits for each. Signage has been placed at the door, "The Code is the Month and the Year". The code will be changed monthly on the 1st of the month. - Staff education related to the new code on a monthly basis and that the doors will be unlocked/disarmed during		

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NAME OF PROVIDER OR SUPPLIER TALAH NURSING AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304		
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F 604	Continued From page 2 R1's care plan dated 3/26/22, indicated R1 used a wheelchair and front wheeled walker in his room. R1's care plan further indicated he was a smoker. R1's Elopement Risk dated 5/23/22, indicated he was at low risk for elopement, was cognitively intact and able to go outside independently. R1's Smoking Assessment dated 6/1/22, indicated R1 was safe to smoke without supervision. During interview 6/1/22, at 12:00 p.m. front desk employee (FD)-A stated she's in charge of unlocking the front door for visitors and residents who enter and exit the facility. The FD-A further stated she was also in charge of making sure the residents who are at risk for a elopement do not leave the facility and that she had a book at the front desk of approximately 10 residents with pictures she was to watch out for to make sure did not leave the facility and not unlock the doors for. During interview 6/1/22, at 4:30 p.m. facility health unit coordinator (HUC) stated the front door have been locked since COVID-19 and she was not sure why they were still locked. The HUC further stated there were two residents who had been going outside to smoke for many months and smoke independently. In addition, HUC stated when he would come to work in the morning, R1 would yell his name and he would help him with the door and then R1 would ring the door bell and he will let him back into the building after he would smoke. During interview on 6/1/22, at 4:33 p.m. R1 stated	F 604	business hours. Staff notified via OnShift message related to the new code on a monthly basis and that the doors will be unlocked/disarmed during business hours. • Audits will be completed weekly x 4 weeks to ensure residents who wish to enter/exit the facility independently are able to do so. • 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 will be responsible for compliance.		

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F 604	Continued From page 3 he can come and go as he wants inside the facility but when he wants to leave the facility he needs to be let outside the front door because it is locked. R1 stated he has arthritis pain during the night and gets up to go smoke and it can take a long time to find someone to let him outside because there is no one at the door in the evening or on the overnight. In addition, R1 stated when he wants to get back in the facility he would ring the door bell and had to wait up to 30 minutes to get let back into the facility which is very frustrating to him. R2's quarterly MDS dated 4/4/22, indicated R2 was cognitively intact, had no wandering behavior and was independent with mobility. R2's care plan dated 3/08/22, indicated R2 exhibited behaviors of getting upset when not being able to leave the facility to smoke on non-scheduled times and will swear at staff and say, "I have my rights!". R2's care plan further indicated he was currently smoking at the facility with out supervision. R2's Elopement Risk dated 5/20/22, indicated he was cognitively intact, no history of wandering and was able to go outside independently. R2 Smoking Assessment dated 5/20/22, indicated R2 was safe to smoke without supervision. During observation and interview on 6/1/22, at 4:20 p.m. R2 was siting outside in front of the building by the facility sign listening to music with his cigarettes next to him. R2 stated he had to be let outside because the front door is locked. R2 stated sometimes if no one is at the front desk he	F 604			

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NAME OF PROVIDER OR SUPPLIER TALAH NURSING AND REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304			
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F 604	Continued From page 4 had to wait up to 10 minutes to be let outside to smoke. R2 stated he does not know why the front door is locked and it is frustrating and he was hoping to discharge soon. During interview on 6/1/22, at 5:00 p.m. regional director (RD) stated the front door is locked for security and also for exit seeking residents. The RD further stated half of his buildings have locked doors or have a WanderGuard system in place and does not feel this should be a concern especially since during daytime hours there is always someone at the front desk to let the residents in and out of the facility if needed. The RD further stated adding a WanderGuard system to the facility would be extremely expensive and did not feel it would be an option. Observation on 6/1/22 of the front entrance noted a set of outside entrance doors leading into a corridor where the main internal doors (locked from inside and out) to the building were. Residents and visitors to the building were observed to be standing inside a corridor, waiting to be let in, eliminating exposure to inclement weather during wait times. A policy was requested on resident rights and was not received.			F 604			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 15, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: OCJ711

Dear Administrator:

The above facility was surveyed on June 1, 2022 through June 1, 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

Talahi Nursing And Rehab Center

June 15, 2022

Page 2

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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

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

Please feel free to call me with any 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

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 06/01/2022
NAME OF PROVIDER OR SUPPLIER TALAH NURSING AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 6/1/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT IN compliance with the MN State Licensure. The following complaints were found to be	2 000			

Minnesota Department of Health

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

Electronically Signed

TITLE

(X6) DATE

06/15/22

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 06/01/2022
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2 000	Continued From page 1 SUBSTANTIATED with no licensing orders cited. H54381908C/MN83843 However, as a result of the investigation, a licensing order was cited at 505. 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 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	2 000			

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2 000	Continued From page 2 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			
2 505	MN Rule 4658.0300 Subp. 1 A-E Use of Restraints Subpart 1. Definitions. For purposes of this part, the following terms have the meanings given. A. "Physical restraints" means any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Physical restraints include, but are not limited to, leg restraints, arm restraints, hand mitts, soft ties or vests, and wheelchair safety bars. Physical restraints also include practices which meet the definition of a restraint, such as tucking in a sheet so tightly that a resident confined to bed cannot move; bed rails; chairs that prevent rising; or placing a resident in a wheelchair so close to a wall that the wall prevents the resident from rising. Bed rails are considered a restraint if they restrict freedom of movement. If the bed rail is used solely to assist the resident in turning or to help the resident get out of bed, then the bed rail is not used as a restraint. Wrist bands or devices on clothing that trigger electronic alarms to warn staff that a resident is leaving a room or area do not, in and of themselves, restrict freedom of movement and should not be considered restraints.	2 505			6/16/22

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2 505	Continued From page 3 B. "Chemical restraints" means any psychopharmacologic drug that is used for discipline or convenience and is not required to treat medical symptoms. C. "Discipline" means any action taken by the nursing home for the purpose of punishing or penalizing a resident. D. "Convenience" means any action taken solely to control resident behavior or maintain a resident with a lesser amount of effort that is not in the resident's best interest. E. "Emergency measures" means the immediate action necessary to alleviate an unexpected situation or sudden occurrence of a serious and urgent nature. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 2 of 2 residents (R1 and R2) were free from physical restraint when being locked within the facility with out medical cause. This had the potential to affect all residents locked in the facility not medical assessed to require such restriction. Findings include: R1's quarterly minimum data set (MDS) dated 2/26/22, indicated R1 was cognitively intact, had no wandering behavior, independent with mobility, impairment on one side of lower extremity and used a walker. R1's care plan dated 3/26/22, indicated R1 used a wheelchair and front wheeled walker in his room. R1's care plan further indicated he was a smoker.	2 505	Corrected		

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2 505	Continued From page 4 R1's Elopement Risk dated 5/23/22, indicated he was at low risk for elopement, was cognitively intact and able to go outside independently. R1's Smoking Assessment dated 6/1/22, indicated R1 was safe to smoke without supervision. During interview 6/1/22, at 12:00 p.m. front desk employee (FD)-A stated she's in charge of unlocking the front door for visitors and residents who enter and exit the facility. The FD-A further stated she was also in charge of making sure the residents who are at risk for a elopement do not leave the facility and that she had a book at the front desk of approximately 10 residents with pictures she was to watch out for to make sure did not leave the facility and not unlock the doors for. During interview 6/1/22, at 4:30 p.m. facility health unit coordinator (HUC) stated the front door have been locked since COVID-19 and she was not sure why they were still locked. The HUC further stated there were two residents who had been going outside to smoke for many months and smoke independently. In addition, HUC stated when he would come to work in the morning, R1 would yell his name and he would help him with the door and then R1 would ring the door bell and he will let him back into the building after he would smoke. During interview on 6/1/22, at 4:33 p.m. R1 stated he can come and go as he wants inside the facility but when he wants to leave the facility he needs to be let outside the front door because it is locked. R1 stated he has arthritis pain during the night and gets up to go smoke and it can take a long time to find someone to let him outside	2 505			

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2 505	Continued From page 5 because there is no one at the door in the evening or on the overnight. In addition, R1 stated when he wants to get back in the facility he would ring the door bell and had to wait up to 30 minutes to get let back into the facility which is very frustrating to him. R2's quarterly MDS dated 4/4/22, indicated R2 was cognitively intact, had no wandering behavior and was independent with mobility. R2's care plan dated 3/08/22, indicated R2 exhibited behaviors of getting upset when not being able to leave the facility to smoke on non-scheduled times and will swear at staff and say, "I have my rights!". R2's care plan further indicated he was currently smoking at the facility with out supervision. R2's Elopement Risk dated 5/20/22, indicated he was cognitively intact, no history of wandering and was able to go outside independently. R2 Smoking Assessment dated 5/20/22, indicated R2 was safe to smoke without supervision. During observation and interview on 6/1/22, at 4:20 p.m. R2 was siting outside in front of the building by the facility sign listening to music with his cigarettes next to him. R2 stated he had to be let outside because the front door is locked. R2 stated sometimes if no one is at the front desk he had to wait up to 10 minutes to be let outside to smoke. R2 stated he does not know why the front door is locked and it is frustrating and he was hoping to discharge soon. During interview on 6/1/22, at 5:00 p.m. regional director (RD) stated the front door is locked for	2 505			

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2 505	Continued From page 6 security and also for exit seeking residents. The RD further stated half of his buildings have locked doors or have a WanderGuard system in place and does not feel this should be a concern especially since during daytime hours there is always someone at the front desk to let the residents in and out of the facility if needed. The RD further stated adding a WanderGuard system to the facility would be extremely expensive and did not feel it would be an option. Observation on 6/1/22 of the front entrance noted a set of outside entrance doors leading into a corridor where the main internal doors (locked from inside and out) to the building were. Residents and visitors to the building were observed to be standing inside a corridor, waiting to be let in, eliminating exposure to inclement weather during wait times. A policy was requested on resident rights and was not received. SUGGESTED METHOD OF CORRECTION: The DON, administrator, or designee (facility) should ensure if attempting to utilize a restraint, the facility should also have a appropriate medical symptom given by the attending physician documented. The facility should ensure staff have tried and documented interventions for the least restrictive environment prior to obtaining written consent from the resident and/or their family and a written order from the attending physician with set parameters to apply the restraint and have specific methods for monitoring. The facility should outline steps to ensure periodically, in consultation with the resident, the family, and the attending physician, staff reevaluate the resident's need for the restraint. The facility	2 505			

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2 505	Continued From page 7 should also ensure those specific measures are care-planned and thoroughly documented. Staff should be re-educated to appropriate policy changes or revision, steps utilized in the acquiring of a restraint, and deemed competent for oversight of their use. The facility should have a method for monitoring the above mentioned actions until a restraint is no longer utilized. The results of those audits should be taken to the QAPI committee ongoing to determine compliance. Additionally, the facility should ensure residents who do not have a medically necessary need for a restraint, have such restraints/barriers removed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 505			