			D CERTIFICAT LETED BY THE		E SURVEY AGENCY	ID: 23SE Facility ID: 00866
1. MEDICARE/MEDICAID PROVIDER NO.       3. NAME AND ADDRESS OF FACILITY         (L1)       245298         2.STATE VENDOR OR MEDICAID NO.       (L4) 305 FREMONT STREET         (L2)       400099400			4. TYPE OF ACTION:       7 (L8)         1. Initial       2. Recertification         3. Termination       4. CHOW         5. Validation       6. Complaint			
5. EFFECTIVE DATE CHANGE OF OW	NERSHIP	7 PROVIDER/SU	PPLIER CATEGORY		<u>02</u> (L7)	7. On-Site Visit 9. Other
(L9)         03/01/2017           6.         DATE OF SURVEY         01/23/           8.         ACCREDITATION STATUS:		<ul> <li>PROVIDEN/SU</li> <li>01 Hospital</li> <li>02 SNF/NF/Dual</li> <li>03 SNF/NF/Distinct</li> </ul>	05 HHA 09 06 PRTF 10	9 ESRD 0 NF 1 ICF/IID	<u>52</u> (L7) 13 PTIP 22 CLIA 14 CORF 15 ASC	8. Full Survey After Complaint FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP 12	2 RHC	16 HOSPICE	12/31
11. LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED AS:			
From (a) : To (b) :		Complian	nce With Requirements ce Based On: Acceptable POC		And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF	6. Scope of Services Limit     7. Medical Director
12.Total Facility Beds	56 (L18)				5. Life Safety Code	9. Beds/Room
13.Total Certified Beds	<b>56</b> (L17)		mpliance with Program and/or Applied Waivers			
14. LTC CERTIFIED BED BREAKDOW	'N	Requirements	and/or Applied walvers	s:	* Code: A 15. FACILITY MEETS	(L12)
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
56	19 514	101				
(L37) (L38)	(L39)	(L42)	(L43)			
6. STATE SURVEY AGENCY REMAR						
See Attached Remarks	K3 (IF AFFLICABL	E SHOW LIC CANCI	ELEATION DATE).			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY A	APPROVAL Date:
Brenda Fischer, Unit	Supervisor	(	02/23/2018	(L19)	_Douglas S. Larson, Enf	forcement Specialist 05/29/2018
PA	ART II - TO BE	COMPLETED	BY HCFA REG	IONAI	OFFICE OR SINGLE ST	ATE AGENCY
<ol> <li>DETERMINATION OF ELIGIBILITY</li> <li>X 1. Facility is Eligible to Pa</li> </ol>			MPLIANCE WITH CIV GHTS ACT:	ΛIL	<ol> <li>Statement of Finan</li> <li>Ownership/Control</li> <li>Both of the Above</li> </ol>	l Interest Disclosure Stmt (HCFA-1513)
2. Facility is not Eligible	(L21)					
22. ORIGINAL DATE	23. LTC AGREEM	ENT 2	4. LTC AGREEMEN	Т	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION 10/01/1985	BEGINNING	DATE	ENDING DATE		VOLUNTARY     00       01-Merger, Closure	INVOLUNTARY 05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburseme	ent 06-Fail to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATIV A. Suspension	VE SANCTIONS of Admissions:			03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change
(L27)	B. Rescind Sus	pension Date:	(L44)			00-Active
			(L45)			
28. TERMINATION DATE:	29	INTERMEDIARY/O	CARRIER NO.		30. REMARKS	
		01111				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	DETERMINATION (02/02/2018)	OF APPROVAL DATE	E		

(L33)

DETERMINATION APPROVAL

FORM CMS-1539 (7-84) (Destroy Prior Editions)

(L32)

**CENTERS FOR MEDICARE & MEDICAID SERVICES** 

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

ID: 23SE Facility ID: 00866

The facility's request for a continuing waiver of the following health deficiency has been forwarded to the CMS Region V Office for its determination:

F-912 42 CFR 483.70(d)(1)(ii) BEDROOMS MEASURE AT LAST 80 SQ FT/RESIDENT.

Approval of the waiver request has been recommended.

# DEPARTMENT OF HEALTH

#### Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245298

February 23, 2018

Ms. Becky Willett, Administrator The Estates at Twin Rivers LLC 305 Fremont Street Anoka, MN 55303

Dear Ms. Willett:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program the Minnesota Department of Human Services that your facility is recertified in the Medicaid program.

Effective January 10, 2018 the above facility is recommended for:

56 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 56 skilled nursing facility beds. Your request for waiver of F-912 has been recommended based on the submitted documentation. You will receive notification from CMS only if they do not concur with our recommendation.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Anne Retenson\_

Licensing and Certification Program Minnesota Department of Health P.O. Box 64900 St. Paul, MN 55164-0900 anne.peterson@state.mn.us Telephone #: 651-201-4206 Fax #: 651-215-9697

# DEPARTMENT OF HEALTH

#### Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 23, 2018

Ms. Becky Willett, Administrator The Estates at Twin Rivers LLC 305 Fremont Street Anoka, MN 55303

RE: Project Number S5298029

Dear Ms. Willett:

On December 18, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 1, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On January 23, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 1, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 10, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 1, 2017, effective January 10, 2018 and therefore remedies outlined in our letter to you dated December 18, 2017, will not be imposed.

Your request for a continuing waiver involving the deficiency cited under F-912 at the time of the December 1, 2017 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

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.

Feel free to contact me if you have questions.

Sincerely,

Anne Retenson\_

Licensing and Certification Program Minnesota Department of Health P.O. Box 64900 St. Paul, MN 55164-0900 anne.peterson@state.mn.us Telephone #: 651-201-4206 Fax #: 651-215-9697

# DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 23, 2018

Ms. Becky Willett, Administrator The Estates at Twin Rivers LLC 305 Fremont Street Anoka, MN 55303

Re: Reinspection Results - Project Number S5298029

Dear Ms. Willett:

On January 23, 2018 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 1, 2017, with orders received by you on December 18, 2017. At this time these orders were found to be corrected.

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,

Anne Retension -

Licensing and Certification Program Minnesota Department of Health P.O. Box 64900 St. Paul, MN 55164-0900 anne.peterson@state.mn.us Telephone #: 651-201-4206 Fax #: 651-215-9697

#### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTA	L
PART I - TO BE COMPLETED BY THE STATE SURVEY AGEN	CY

ID: 23SE

PART	I - TO BE COMPLETED BY THE STAT	<b>FE SURVEY AGENCY</b>	Facility ID: 00866
1.         MEDICARE/MEDICAID PROVIDER NO.           (L1)         245298           2.STATE VENDOR OR MEDICAID NO.         (L2)           400099400         (L2)	<ul> <li>3. NAME AND ADDRESS OF FACILITY</li> <li>(L3) THE ESTATES AT TWIN RIVERS L</li> <li>(L4) 305 FREMONT STREET</li> <li>(L5) ANOKA, MN</li> </ul>	LC (L6) 55303	4. TYPE OF ACTION:     2 (L8)       1. Initial     2. Recertification       3. Termination     4. CHOW       5. Validation     6. Complaint       7. On-Site Visit     9. Other
5. EFFECTIVE DATE CHANGE OF OWNERSHIP	7. PROVIDER/SUPPLIER CATEGORY	<u>02</u> (L7)	
(L9)       03/01/2017         6.       DATE OF SURVEY       12/01/2017       (L34)         8.       ACCREDITATION STATUS:       (L10)         0       Unaccredited       1 TJC         2       AOA       3 Other	01 Hospital05 HHA09 ESRD02 SNF/NF/Dual06 PRTF10 NF03 SNF/NF/Distinct07 X-Ray11 ICF/IID04 SNF08 OPT/SP12 RHC	13 PTIP 22 CLIA 14 CORF 15 ASC 16 HOSPICE	8. Full Survey After Complaint FISCAL YEAR ENDING DATE: (L35) 12/31
11LTC PERIOD OF CERTIFICATION	10.THE FACILITY IS CERTIFIED AS:		
From (a): To (b):	A. In Compliance With Program Requirements Compliance Based On:	And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN	6. Scope of Services Limit 7. Medical Director
12.Total Facility Beds 56 (L18)	1. Acceptable POC	4. 7-Day RN (Rural SNF)	8. Patient Room Size 9. Beds/Room
13.Total Certified Beds 56 (L17)	<b>X</b> B. Not in Compliance with Program	5. Life Safety Code	_
14. LTC CERTIFIED BED BREAKDOWN	Requirements and/or Applied Waivers:	* Code: <b>B</b> * 15. FACILITY MEETS	(L12)
18 SNF 18/19 SNF 19 SNF	ICF IID	13. TACIENT MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)
56			
(L37) (L38) (L39)	(L42) (L43)		
16. STATE SURVEY AGENCY REMARKS (IF APPLICAB	LE SHOW LTC CANCELLATION DATE):	I	
See Attached Remarks			
17. SURVEYOR SIGNATURE	Date :	18. STATE SURVEY AGENCY A	PPROVAL Date:
Jennifer Bahr, HFE-NE II	01/31/2018 (L19)	Anne Peterson, Enforce	ment Specialist 2/02/2018
PART II - TO B	E COMPLETED BY HCFA REGIONAL	L OFFICE OR SINGLE STA	
19. DETERMINATION OF ELIGIBILITY        1. Facility is Eligible to Participate        2. Facility is not Eligible         (L21)	20. COMPLIANCE WITH CIVIL RIGHTS ACT:	<ol> <li>Statement of Finance</li> <li>Ownership/Control</li> <li>Both of the Above :</li> </ol>	Interest Disclosure Stmt (HCFA-1513)
22. ORIGINAL DATE 23. LTC AGREE	MENT 24. LTC AGREEMENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION BEGINNING 10/01/1985	G DATE ENDING DATE	VOLUNTARY         00           01-Merger, Closure         01	INVOLUNTARY 05-Fail to Meet Health/Safety
(L24) (L41)	(L25)	02-Dissatisfaction W/ Reimbursemer	nt 06-Fail to Meet Agreement
	IVE SANCTIONS on of Admissions:	03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change
(L27) B. Rescind St	(L44) Ispension Date:		00-Active
	(L45)		
28. TERMINATION DATE: 2	9. INTERMEDIARY/CARRIER NO.	30. REMARKS	
(L28)	<b>01111</b> (L31)		
31. RO RECEIPT OF CMS-1539	2. DETERMINATION OF APPROVAL DATE	Annual Health Waiver s	tent to CMS 02/15/2018 Co.
(L32)	(L33)	DETERMINATION APPRO	OVAL

DEPARTMENT OF HEALTH AND	HUMAN SERVICES	CENTERS FOR MEDICARE & M	EDICAID SERVICES
	MEDICARE/MEDICAID CERTIFICATION AND T	TRANSMITTAL	ID: 23SE
	PART I - TO BE COMPLETED BY THE STATE SU	RVEY AGENCY	Facility ID: 00866
C&T REMARKS - CMS 1539 FORM	STATE AGENCY REMARKS		

The facility's request for a continuing waiver of the following health deficiency has been forwarded to the CMS Region V Office for its determination:

# F-912 42 CFR 483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT.

Approval of the waiver request has been recommended.



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered December 18, 2017

Ms. Becky Willett, Administrator The Estates at Twin Rivers LLC 305 Fremont Street Anoka, MN 55303

RE: Project Number S5298029

Dear Ms. Willett:

On December 1, 2017, a standard survey was completed at your facility by the Minnesota Departments 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.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

# Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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.

# DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor St. Cloud A Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health Midtown Square 3333 Division Street, Suite 212 Saint Cloud, Minnesota 56301-4557 Email: brenda.fischer@state.mn.us Phone: (320) 223-7338 Fax: (320) 223-7348

# **OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES**

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by January 10, 2018, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by January 10, 2018 the following remedy will be imposed:

• Per instance civil money penalty. (42 CFR 488.430 through 488.444)

# ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

## PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. 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 the respective deficiencies (if any) is acceptable.

The Estates at Twin Rivers LLC December 18, 2017 Page 4

## VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

### Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

### Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

## Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by March 1, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

The Estates at Twin Rivers LLC December 18, 2017 Page 5

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 1, 2018 (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.

## INFORMAL DISPUTE RESOLUTION

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</u>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145 The Estates at Twin Rivers LLC December 18, 2017 Page 6

> Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions related to this electronic letter.

Sincerely,

Anne Retenson\_

Licensing and Certification Program Minnesota Department of Health P.O. Box 64900 St. Paul, MN 55164-0900 anne.peterson@state.mn.us Telephone #: 651-201-4206 Fax #: 651-215-9697

	-	ID HUMAN SERVICES			FOF	RM APPROVED
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DAT	O. 0938-0391 TE SURVEY IPLETED
		245298	B. WING		1:	2/01/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
THE ESTA	TES AT TWIN RIVERS L	LC		305 FREMONT STREET ANOKA, MN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 00	ю		
F 645 SS=D	survey was complete Minnesota Departme Estates at Twin River compliance with the r 483, subpart B, requi Facilities. The facility's plan of c as your allegation of c Department's accepta enrolled in ePOC, you at the bottom of the fi form. Your electronic be used as verificatio Upon receipt of an ac on-site revisit of your validate that substant regulations has been your verification. PASARR Screening f CFR(s): 483.20(k)(1) §483.20(k) Preadmis- individuals with a me with intellectual disab §483.20(k)(1) A nursi or after January 1, 19 (i) Mental disorder as (i) of this section, unle authority has determi independent physical performed by a perso	ance. Because you are ur signature is not required rst page of the CMS-2567 submission of the POC will n of compliance. Ecceptable electronic POC, an facility may be conducted to ial compliance with the attained in accordance with or MD & ID (3) sion Screening for ntal disorder and individuals ility. Ing facility must not admit, on 189, any new residents with: defined in paragraph (k)(3) ess the State mental health	F 64	5		1/10/18
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE
	cally Signed					12/27/2017

**Electronically Signed** 

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.

PRINTED: 01/31/2018

			(V(2) • • · · · -		
d plan of	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245298	B. WING _		12/01/2017
AME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE
HE ESTA	ATES AT TWIN RIVERS L	LC		305 FREMONT STREET ANOKA, MN 55303	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( X (EACH CORRECTIVE ACT) CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETIC TE APPROPRIATE DATE
F 645	Continued From pag	e 1	F 6	645	
		idual, the individual requires provided by a nursing facility;			
	(B) If the individual requires such level of services, whether the individual requires				
	(k)(3)(ii) of this section	lity, as defined in paragraph on, unless the State			
	authority has determ	or developmental disability ined prior to admission- the physical and mental			
	condition of the indiv	idual, the individual requires provided by a nursing facility;			
	(B) If the individual re services, whether the	-			
		tions. For purposes of this			
	(i)The preadmission paragraph(k)(1) of th	screening program under is section need not provide			
F F t (	preadmission screen paragraph (k)(1) of th	nis section to the admission			
	hospital after receiving	t an individual- to the facility directly from a ng acute inpatient care at the			
	(B) Who requires nu	rsing facility services for the ne individual received care in			
	<ul> <li>(A) Who is admitted hospital after receivin hospital,</li> <li>(B) Who requires nun condition for which the the hospital, and</li> </ul>	to the facility directly from a ng acute inpatient care at the rsing facility services for the ne individual received care in physician has certified,			

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TATEMENT (	DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245298	B. WING			12	/01/2017
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	E ESTATES AT TWIN RIVERS LLC			3	05 FREMONT STREET		
		20		Δ	NOKA, MN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 645	Continued From page	e 2	E E	645			
		s than 30 days of nursing		040			
	§483.20(k)(3) Definiti section-	on. For purposes of this					
	(i) An individual is co	nsidered to have a mental ual has a serious mental					
	disorder defined in 48						
	(ii) An individual is co						
	-	if the individual has an					
	or is a person with a	as defined in §483.102(b)(3)					
	described in 435.101						
		Γ is not met as evidenced					
	by:						
	Based on observatio	n, interview and document led to ensure a Level II			PASRR was obtained for Resident R1	7.	
	preadmission screen	•			Admission team and facility manageme	ent	
		eted for 1 of 1 residents			team members that assist with		
	(R17) reviewed for pr	readmission screening.			admissions will be educated on PASRF		
	Eindingo includo:				and the importance of completed scree	n	
	Findings include:	identified on the facility face			to be provided to the facility prior to admission.		
		e of 12/1/17, included			SW or assigned facility representative t	o	
		essive disorder and bipolar			review PASRR with admission paperwo		
	disorder. The face sl				and facilitate any necessary follow up.		
	admission date to the				Screens indicating a Level 2 will have a	a	
					scheduled follow you from the count an	d	
	-	n 11/29/17, at 11:50 a.m.			facility representative will follow up with		
		nd dressed for the day, her room, and conversing			the county if Level 2 documentation is received.	not	
					Facility Audit completed of the PASRR	to	
	A review of R17's me	dical record included a			ensure that all residents have received		
	document from the S	enior LinkAge Line. The			appropriate follow up. Admissions will b	e	
		otember 29, 2017 was the			audited upon admission to ensure PAS		
		screening results requested			compliance for 1 month and then as		
	by P17's bospico pro	vider, prior to R17's current	1		needed.		1

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		D HUMAN SERVICES MEDICAID SERVICES			F	NTED: 01/31/2018 ORM APPROVED 3 NO. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	E CONSTRUCTION	(X3)	DATE SURVEY COMPLETED
		245298	B. WING			12/01/2017
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP	P CODE	
THE ESTA	TES AT TWIN RIVERS LI	_C	3 A			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETION DATE
F 645	indicated in the section Reconciliation Act) Let appears "this person MI and needs to be re- for further evaluation." medical record indicat PASRR screen currer When interviewed on director of social serve 'PAS' (pre admission a screening was indicat made a call in early O admission, to Hennep up to get the level 2 s one may have been of find it. The DSS state Hennepin County toda the level II screening. R17's care plan, with identified mood and b problem/strength area did not identify any dia interventions or other needs for R17. R17's physician's order identify any order for a programming, or other 11/30/17, included do R17's PASRR on 10/ notes regarding R17's	ing home. The document n OBRA (Omnibus Budget vel 1 MI (mental illness): It [R17] meets the criteria for iferred to the lead agency " A further review of R17's ted there was no level 2 htty completed. 11/20/17 at 12:40 p.m., the ices (DSS) stated R17's iscreen) identified a level 2 ed. The DSS stated she October, shortly after R17's in County regarding follow creen for R17 and thought ompleted but was unable to d she would contact ay, and expected a FAX of a start date of 10/10/17, ehavior and activities as as; however, the care plan agnosis-specific therapeutic-programming ers, dated 9/29/17, did not special therapy, r mental health services. gress notes from 9/1/17 to cumentation regarding 4/17. Subsequent progress	F 645		es or designee arty. ew results and ange when ntinuation or ring process	
	-	ing the survey (11/18 to				

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TATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPL	ETED
		245298	B. WING		12/0	1/2017
NAME OF PI	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE	•	
THE ESTA	TES AT TWIN RIVERS L	LC		FREMONT STREET DKA, MN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 645	Continued From page	9 4	F 645			
F 656 SS=E	3:00 p.m., the DSS si subsequently contact she thought would co evaluation, she learn been completed, and closed the file. The L County had been inve- there were referrals r with a PASRR Level there were mix-ups w acknowledged "there screen completed for A facility policy, Pre-A revised 1/2017, indica ensure that residents center meet specified of placement. The po social worker will che screening and OBRA Develop/Implement C CFR(s): 483.21(b)(1) §483.21(b) Compreh §483.21(b)(1) The fac implement a compref care plan for each res resident rights set for §483.10(c)(3), that in objectives and timefra medical, nursing, and needs that are identif assessment. The cor describe the following	ed Hennepin County, whom implete the level II ed that a screen had not a case worker essentially DSS also stated Anoka olved in R17's case and nade, but none having to do II for R17. The DSS stated with contact information, and was no current" level II R17. Admission Screening (PAS), ated it's purpose was "To admitted to the health care I criteria for appropriateness olicy direct under #1: The ck for preadmission Level II requirements. Comprehensive Care Plan ensive Care Plans cility must develop and hensive person-centered sident, consistent with the th at §483.10(c)(2) and cludes measurable ames to meet a resident's I mental and psychosocial ied in the comprehensive nprehensive care plan must Q- are to be furnished to attain	F 656			1/10/18

Facility ID: 00866

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FC	ED: 01/31/2018 RM APPROVED NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) D.	ATE SURVEY MPLETED
		245298	B. WING			12/01/2017
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, Z	•	
			3	05 FREMONT STREET		
	TES AT TWIN RIVERS L		A	NOKA, MN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE	(X5) COMPLETION DATE
F 656	required under §483.2 (ii) Any services that y under §483.24, §483. provided due to the re- under §483.10, include treatment under §483 (iii) Any specialized ser- rehabilitative services provide as a result of recommendations. If findings of the PASAF rationale in the resider (iv)In consultation with resident's representation (A) The resident's good desired outcomes. (B) The resident's pre- future discharge. Fac- whether the resident's community was asser- local contact agencies entities, for this purpor (C) Discharge plans in plan, as appropriate, requirements set forth section.	psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required 25 or §483.40 but are not esident's exercise of rights ling the right to refuse .10(c)(6). ervices or specialized the nursing facility will PASARR a facility disagrees with the RR, it must indicate its .nt's medical record. In the resident and the tive(s)- als for admission and deference and potential for ilities must document is desire to return to the ssed and any referrals to s and/or other appropriate	F 656			
	by: Based on interview a faciltiy failed to ensur- were developed for ra splints and activities f	nd document review the e comprehensive care plans ange of motion (ROM), or 1 of 7 residents (R15) upon staff for activities of		Resident R15 is provid range of motion program recommended by theral splint applied at bedtime the morning. R15's care updated to reflect range program and splint use, participation, and interv implemented to meet id	n as py, to include a e and removed in e plan has been e of motion and activity goals, entions	

Event ID: 23SE11

Facility ID: 00866

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED
		245298	B. WING		12/01/2017
NAME OF PI	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE	
THE ESTA	TES AT TWIN RIVERS L	LC		305 FREMONT STREET ANOKA, MN 55303	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETIC
F 656	Continued From page	e 6	F 656		
	Continued From page 6 R15's annual MDS, 10/2/17, identified R15 had no upper or lower extremity impairments, no rejection of cares and was not involved in a nursing rehabilitation program. Review of R15's Occupational Therapy (OT) note, 9/26/16 identified R15 had right hemiparesis (paralysis right side of body) with trace movement of his right fingers, no active range of motion in elbow or shoulder, and PROM within functional limited with verbalization of pain when should flexion past 140 degrees. The Therapy Communication form dated, 10/31/16, identified for nursing to apply right hand splint to R15 at hour of sleep and remove with morning cares and clean his hand.			All residents will continue to be of any maintenance program as recommended by therapy. Audit therapy record and nursing has b completed to ensure that they ar included in the plan of care. Nurs will follow recommendations and re-approach and/or document up refusals. Process has been imple to improve therapy to nursing communication. Nursing will com provide proper ROM. An audit of dependent residents care plans completed by therapeutic progra director on December 20, 2017. activity care plans include goals interventions.	of been e sing staff pon emented tinue to f all was m These
	form, dated, 12/1/201 maintenance program right upper extremity to shoulder, elbow an The occupational the summary, 12/2/16, id right upper extremity splinting schedule on day. Review of R15's occu 9/25/17 identified bila passive range of moti limits. Limited range of hemiparesis/brain inju on functional mainten	rapy (OT) discharge entified nursing to continue ROM, and right hand at night and off during the upational therapy note, teral upper extremity ion (PROM) within functional		<ul> <li>Education has been completed w therapy and clinical staff regardir newly revised communication pro- include nurse manager initially re- all therapy communications and plan of care is developed and fol Education will be provided to the Therapeutic Program Director or that all residents are assessed for preferences, goals, and participal are completed.</li> <li>Range of motion audits will be co- by Director of Nursing or designer x4 and as needed. During this au nursing will collaborate with thera ensure recommendations are cu- the care plan, point of care and r assistant care guides. Activity pla</li> </ul>	ng the bocess to eceiving ensuring lowed. In ensuring bor activity ation logs bompleted be weekly udit, apy and rrent on bursing

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						IO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION	· · ·	E SURVEY IPLETED
		245298	B. WING		1:	2/01/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
THE ESTA	ATES AT TWIN RIVERS L	LC		305 FREMONT STREET ANOKA, MN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 656	1 0		F 65	6		
		note 10/3/17 identified a d to continue the program, ed or declined.		Administrator or designee will be responsible.	•	
	problem with physica mobility impairment,	t date 12/1/17, identified a I functioning related to but did not address the use or any restorative nursing e care plan.		QAPI committee rill review result provide redirection or change wh necessary and dictate continuati completion of this mentoring pro based on compliance.	ien on or	
	record (TAR) from Se November 2017, did	treatment administration eptember 2017 through not identify any range of splint identified as part of the				
	sheets, a form used l identified under R15' splint on when in bed	s ADL's were "Right hand I, off in AM [morning]." There ny nursing rehabilitative				
	Physical Therapy (DF functional maintenan 3/16/17 and the last t identified he was still to right hand. There w FMP or splinting proc	2/01/17 12:13 p.m. Director PT) stated R15 was on a ce program with PROM on therapy note on 10/3/17 on that program and a splint was no mention that R15 gram had been stopped and eiving this as identified in the				
	nursing (DON) stated right hand splint, but FMP PROM program	/01/17 12:35 p.m. director of I she was aware (R15) had a did not know (R15) had a n. The DON reported R15's htify the right hand splint or ram which should be				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DAT	E SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COM	IPLETED
		245298	B. WING		12	2/01/2017
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP COD	DE	
THE ESTA	TES AT TWIN RIVERS L	LC		05 FREMONT STREET NOKA, MN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 656			F 656			
	included as part of th	e care plan.				
	10/2/17 identified R1 needed extensive to activities of daily livin were identified by the identified R15's prefe newspaper, music, a group of people, impo					
	Review, dated 10/2/1 attendance and partir resident has joined g such as meals in the	MHM Activity Participation 7 identified under the cipation summary. The roup activities infrequently dining room, snack cart and				
activities such as Resident does at which limits partio activities as ident family and indepe watching sports. military veteran. a identified the plan per care plan, go	activities such as war Resident does attend which limits participal activities as identified family and independe watching sports. Res military veteran. and identified the plans re	d dialysis three times a week tion. Resident's favorite I as he prefers visits form ent activities. Resident enjoys ident if proud of being a the activity plan review emain appropriate/current as ere met and interventions				
	not have any informa	blan print date, 12/1/17, did tion about activity goals, entions implemented to				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/31/2018 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE	
		245298	B. WING		_	12/	01/2017
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE ESTA	TES AT TWIN RIVERS LI	LC		05 FREMONT STREET			
			<b>I</b>				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	Continued From page		F 656				
	before his care confe	of his activity participation rence, and then an annual					
		ion F of the MDS. On a k his participation. She was					
		activity goals were or how					
	this was measured or						
	unable to physically p						
	without staff assistant	-					
	completed a compreh his activity needs.	ensive care plan to meet					
F 657	Care Plan Timing and	Revision	F 657				1/10/18
SS=E	CFR(s): 483.21(b)(2)(						1,10,10
		ensive Care Plans prehensive care plan must					
	be- (i) Developed within 7 the comprehensive as	days after completion of					
	-	terdisciplinary team, that					
	includes but is not lim						
	(A) The attending phy						
	(B) A registered nurse resident.	e with responsibility for the					
	(C) A nurse aide with resident.	responsibility for the					
	(D) A member of food	and nutrition services staff.					
		ticable, the participation of					
		esident's representative(s).					
		be included in a resident's participation of the resident					
		resentative is determined					
	not practicable for the	e development of the					
	resident's care plan.	ataff an nucleonic I- in					
		staff or professionals in ined by the resident's needs					
	or as requested by the						

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		ND HUMAN SERVICES MEDICAID SERVICES				M APPROVE 0. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY IPLETED
		245298	B. WING		12	2/01/2017
NAME OF PF	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
			3	305 FREMONT STREET		
THE ESTA	TES AT TWIN RIVERS L	LC	4	ANOKA, MN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 657	Continued From pag	e 10	F 657			
1 007			F 057			
	team after each asse comprehensive and assessments.					
		T is not met as evidenced				
	by: Based on observation	on, interview and document		Resident R25 has a current smol	kina	
		iled to revise resident care		assessment completed and care	•	
		nterventions for 2 of 3		updated, R1 care plan was updat		
		reviewed for accidents, 1 of		reflect current bed/mattress being		
	3 (R15) residents rev	viewed for pressure ulcers, 1		R34 care plan was made current	to reflect	
	. ,	reviewed for incontinence,		current bowel and bladder needs,		
	and 1 of 5 residents	(R26) reviewed for		had antidepressant and anticoagu		
	medication.			and monitoring removed from car		
	Findings include:			R15 care plan updated to reflect of turning and repositioning schedul		
	ACCIDENTS			Licensed nurses will update care	plans as	
	R25 had the diagnos	es of alcohol-induced		needed with changes of condition	and	
		and cirrhosis of the liver,		with quarterly and annual assessi		
		e, essential hypertension and		complete care plan audit remains		
		the facility undated face		process for all current residents re	-	
		inimum data set (MDS),		at the Estates at Twin Rivers. All	-	
		ated R25 was cognitively ited assistance with activities		pressure ulcer, turning and repos bowel and bladder, and orders we		
	of daily living (ADLs)			reviewed for all pertinent resident		
		or ADLs indicated R25		plans were reviewed and updated		
	needed assistance w	vith ADLs, this resident did d, and the assistant level		December 26, 2017.		
	varied from day to da			Nurses will be educated on an on	going	
	-	-		basis on how and when to update	care	
		eturning back inside after		plans as appropriate.		
		′ at 6:27 p.m R25 was				
		ny clothing or shin burns.		Random care plan revision audits		
		supervised nor adaptive		completed weekly x 4 as indicated		
	equipment such as a	smoking apron.		Re-education will then be provide documentation if warranted.	a with	
	During a medication	pass observation on				
	11/30/17 at 8:10 a.m			Director of Nursing or designee w		

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							B NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3)	DATE SURVEY COMPLETED
		245298	B. WING				12/01/2017
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
THE ESTA	ATES AT TWIN RIVERS L	LC			FREMONT STREET OKA, MN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 657	Continued From page	e 11	F 65	57			
		-A for two cigarettes, which			responsible.		
		e, resident did not display			QAPI committee will review results a	and	
		behaviors. LPN-A stated the			provide redirection or change when		
	-	garettes in the medication a day he smokes where he			necessary and dictate continuation of completion of this monitoring proces		
		each time. LPN-A stated that			based on compliance date.	3	
		ent with smoking and doesn't					
	10/24/17, the facility is independent with small issues once or twice accidentally dropping concerns at present." assessments, dated & supervisor, and the a indicted R25 needed was no mention for th on the 10/24/17 asse Review of R25's care	ng Evaluation, last assessed indicated: "Resident is oking. Resident has had a in the past 3-4 months of his cigarette, however no I In further review of previous 8/24/17, R25 needed ssessment dated 3/23/17, a smoking apron. There he use of a smoking apron ssment.					
	injury related to: Smo Goal indicated: "I will injuries." The interve facility would "observ smoking behaviors of material from outside	At risk for smoking related bkes with supervision. The have no smoking related ntions included: that the ve patient for unsafe r attempts to obtain smoking sources" and that the e smoking apron while					
	director or nursing (D "supervising R25 with are not outside, while	n 11/30/17 at 12:10 p.m., the ON) stated the facility is still h his smoking, even if they they are holding on to his stated the smoking apron					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		245298	B. WING			12	/01/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
THE ESTA	TES AT TWIN RIVERS LI	LC			05 FREMONT STREET ANOKA, MN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 657	R1's admission Minim indicated R1 had no s understood and had r depression. The MDS assistance to transfer with locomotion on the aphasia (loss of ability speech, caused by br schizoaffective disord had two or more falls admission. R1's care plan dated at risk for falls and ind was in place. During observation or was lying in a bariatric concave mattress. During interview on 1 stated R1 used to hav his mattress was repli- did not know when the During interview on 11 stated R1's concave r a bariatric bed as R1 thought that would he care plan should have current interventions. Documentation on wh	ue to resident refusals. num Data Set dated 8/17/17, speech and was rarely noderately severe and extensive assistance e unit. Diagnoses included y to understand or express ain damage) stroke and er. The MDS indicated R1 without injury since 11/10/17, indicated R1 was dicated a concave mattress h 11/29/17, at 6:00 p.m. R1 c sized bed without a 1/29/17, at 7:43 p.m. NA-J /e a concave mattress but aced with a larger bed. NA-J e mattress was replaced. 2/1/17, at 10:27 a.m. DON mattress was replaced with moves a lot in bed, and dp prevent falls. DON stated e been revised to reflect	F	657			

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PRINTED: 01/31/2018

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 01/31/2018 APPROVED D. 0938-0391
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		(X3) DATE	
		245298	B. WING			_	12/	01/2017
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, S	TATE, ZIP CODE		
THE ESTA	TES AT TWIN RIVERS LI	LC			805 FREMONT STREET ANOKA, MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 657	R34 had an indwelling frequently incontinent dated 9/29/17, indicat eliminations and had tube in place related t ulcers. R34's Doctor Order S staff to discontinue th R34's Doctor Order S directed staff to disco During observation or R34 was having wour and did not have a Fo place. During interview on 11 stated R34's care plan when R34's rectal tub removed. PRESSURE ULCERS R15's annual Minimut 10/2/17 identified R15 needed extensive to t activities of daily living ulcer (PU) developme PU (Partial thickness a shallow open ulcer 17 R15 received treatme devices in chair, bed program and PU treat	S dated 10/6/17, identified g catheter and was s of bowel. R34's care plan ted R34 had an alteration in a Foley catheter and rectal to unstageable pressure sheet dated 10/6/17, directed e rectal tube. sheet dated 10/13/17, ntinue the Foley catheter. In 11/28/17, at 10:36 a.m. nd care done to his buttocks oley catheter or rectal tube in 2/1/17, at 9:54 a.m. DON n should have been revised be and Foley catheter were S m Data Set (MDS) dated, 5 had severe cognition, total assistance for all g, was at risk for pressure ent, and a current stage 2 loss of dermis presenting as with a red-pink wound bed). ent of pressure reductions and was on a hydration	F	657				

Facility ID: 00866

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	: 01/31/2018 APPROVED . 0938-0391
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE : COMPL	SURVEY
		245298	B. WING			12/0	01/2017
NAME OF PF	ROVIDER OR SUPPLIER		ST	TREET ADDRESS, CITY, STA	TE, ZIP CODE		-
THE ESTA	TES AT TWIN RIVERS LI	_C		95 FREMONT STREET NOKA, MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 657	was incontinent of box assistance with turnin scale (scoring system PU) was 14 (moderate breakdown. Although for R15 was turned an frequency was not ide R15's care plan print of was at risk for PU dev of stage 3 and 2 press stage 2 PU on his coor conduct a weekly skin pressure reducing cus apply barrier cream at and turn and reposition assessment. Although there was a turning an this was not added to During interview on 1° stated (R15's) care pl	ad nurse practitioner, iir mattress to bed. Resident wel and bladder, needs g and repositioning. Braden to determine risk level for e risk) risk for further the assessment identified nd repositioned, but the entified. date 12/1/17 identified R15 velopment and had a history sure ulcers with a current ccyx. Staff were directed to assessments, provide shion in chair, and bed, fter incontinence, toilet plan on schedule per n the assessment identified nd repositioning schedule,	F 657				
	heat failure (CHF), ma pain, chronic kidney o essential hypertension sheet. The quarterly M	n, undated facility face Ainimum Data Set (MDS), ated R26 was cognitively f set up and limited					

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 01/31/2018 APPROVED D: 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		CONSTRUCTION		(X3) DATE	
		245298	B. WING			_	12/	01/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE ESTA	TES AT TWIN RIVERS LI	LC			05 FREMONT STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE) CROSS-REFERE	B PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 657	Continued From page	9 15	F	657				
		the hospital during the first 18) and returned to the survey (12/01/17).						
	In review of R26's car 8/03/17), it was noted identified the two follo monitoring medication	owing concerns for						
	Coumadin (a blood th process of DVT [deep pulmonary embolism The intervention secti	Anticoagulant therapy inner) r/t [related to: diease o vein thrombosis], [blood clots to the lungs]." on directed staff to monitor f bleeding, and medications						
	drug reactions] r/t [rel psychotropic medicat antidepressant) for th The staff were directe medication for discon	ion. Receives Cymbalta (an e diagnosis of depression." ed to being tapering the tinuation, and update the sysician assistant) regarding						
	10/26/17, there was n receiving either Courr review, it was docume received an order on Cymbalta to 60 milligr that it was OK to disc 2 week if symptoms of received an order on Cournadin medication	8/15/17 to decrease the rams (mg) everyday, and ontinue this medication after lo not return. The facility 10/11/17 to discontinue the						

Facility ID: 00866

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	S FOR MEDICARE &		()(0)		OMB NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245298	B. WING		12/01/2017
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE	
THE ESTA	TES AT TWIN RIVERS L	LC		305 FREMONT STREET ANOKA, MN 55303	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETIC
F 657	plan was not revised	e 16 ON) stated that R26's care after the discontinuation of nd Cymbalta medications.	F 657		
F 659 SS=D	A policy on care plan and was not provided Qualified Persons CFR(s): 483.21(b)(3)		F 659		1/10/18
	as outlined by the cor must- (ii) Be provided by qu accordance with each care. This REQUIREMENT	d or arranged by the facility, nprehensive care plan,			
	review, the facility fail for activities, oral care 3 of 5 residents (R39, were dependent upor activities of daily living Findings include: ACTIVITIES R1's admission Minim indicated R1 had no s understood and had r depression.	num Data Set dated 8/17/17, speech and was rarely moderately severe		R1 activity plan of care/care guide has been updated to provide further communication to the clinical team ar other disciplines. Staff to assist R1 up shift and stay with resident. IPad and available for stimulation; nursing staff offer. R39 ADL care plan has ben up to reflect current oral care needs and refusals. Risk and benefits regarding care refusal has been completed and will continue to offer assistance. R15 personal hygiene care plan has been update to reflect current needs and preference including shaving and star continue to assist as indicated.	nd o per TV f to dated oral staff
	altered socialization of communicate. Goals continue daily indepe	1/10/17, indicated R1 had due to the inability to for R1 included R1 would ndent activities in his room ort one on one weekly visits.		All residents will continue to be provid care as outlined by their individual/comprehensive care plan. / resident's were audited and care plar	<b>A</b> II

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/31/2018 M APPROVED O. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245298	B. WING _			12	/01/2017
NAME OF PI	ROVIDER OR SUPPLIER	•	•	ST	IREET ADDRESS, CITY, STATE, ZIP CODE	•	
	TES AT TWIN RIVERS L			30	05 FREMONT STREET		
		20		Α	NOKA, MN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 659	Continued From page	<u>-</u> 17	F 6	50			
	Interventions included	d providing R1 with with evision and other activities.			to their individual preference.		
	2:28 p.m. R1 was lyir without any music, te staff aside from requi turning and reposition During interview on 1 member (FM)-A state visited, on almost a d lying in bed without a During observations of 6:20 p.m. R1 was lyir without any music, te staff aside from requi turning and reposition During interview on 1 assistant (NA)-J state	1/28/17, at 2:30 p.m. family ed R1 when the family laily basis) R1 was always ny music or television. on 11/29/17, at 1:00 p.m. to ng in bed. The lights were on levision or interaction from red care (medications, ning) from staff. 1/29/17, at 7:43 p.m. nursing ed R1 spent most of his time t have music or a television			Staff including clinical department will re-educated on reviewing, following as providing cares based upon the reside plan of care including personal hygier and activity needs. Audits will be completed weekly x 4 weeks, then as needed regarding; spe resident care planned cares such as of cares, shaving, and giving opportunitie for stimulating activity. Director of Nursing or designee will be responsible. QAPI committee will review results an provide redirection or change when necessary and dictate continuation of completion of this monitoring process based on compliance date.	nd ent's le ecific oral es	
	through 12:37 p.m. w were on without any r interaction from staff (medications, turning staff. During interview on 1 director of nursing (D care plan should be fr ORAL CARE	aside from required care and repositioning) from 2/1/17, at 10:27 a.m. ON) stated R1's current					

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		MEDICAID SERVICES				<u>IO. 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	· · ·	TE SURVEY MPLETED
		245298	B. WING		1	2/01/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
THE ESTA	ATES AT TWIN RIVERS L	LC		305 FREMONT STREET ANOKA, MN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 659	Continued From page	e 18	F 65	59		
		ognitive, social or emotional				
		iplegia, and also indicated				
		ve assistance of staff to				
	-	MDS also indicated R39				
		R39's care plan, revised				
		39 had a physical functioning to brush teeth after set up.				
		to blush teeth alter set up.				
	During observation o	n 11/30/17 beginning at 6:51				
		cal nurse entered R39's room				
	-	ar. After getting the blood				
		ited the room and provided and jelly to eat in response to				
		r. At 8:22 a.m., licensed				
	-	)-A entered R39's room to				
		ar, and left the room when				
		A)-B greeted R39 to begin				
		3 gathered care supplies,				
		nd began R39's morning ed and dressed R39, then				
		ler R39. Using a mechanical				
	lift, and with assistan					
	transferred R39 from	the bed into the wheelchair.				
	-	s face, combed his hair, and				
		as anything else he needed,				
	to which R39 shook h	nis nead. During this B did not offer or provide any				
	-	IA-B told R39 she would				
		then exited the room				
		soiled items from the room.				
		om at 8:44 a.m., NA-B				
	transported R39 into					
	preaktast, again with	out offer of oral cares.				
	-	at 9:43 a.m., NA-B wheeled				
		n, where R39 expressed				
	-	the wheel chair and watch				
	IV. INA-B adjusted t	he TV and headphones to				

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	-	ID HUMAN SERVICES				FORM	: 01/31/2018 APPROVED
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	CONSTRUCTION		OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
245298			B. WING			12/01/2017	
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, S	TATE, ZIP CODE	-	
THE ESTA	ATES AT TWIN RIVERS LI	∟C		05 FREMONT STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 659	R39's likings, placed to chair and exited R39's provision nor offer to p following breakfast. Funtil after he was assis his room at 12:08 p.m When interviewed on NA-b stated she had b this morning and miss I just forgot to offer too that (R39) was depen his oral cares. During interview on 1° stated the care plan s should be offered and teeth. LPN-A stated more than once if nee brushing "should have When interviewed on director of nursing (D0 should be at least offer evening to all residen expected oral cares n residents, not forced, re-approach or have a DON stated staff were twice daily." SHAVING R15's annual Minimur 10/2/17 identified R15 needed extensive to t	the call light on the wheel s room. Again there was no provide oral cares to R39 R39 remained in his chair isted to eat the noon meal in n. 11/30/17 at 12:30 p.m., lots of residents to assist sed to offer R39 oral cares. " oth brushing." She stated ident upon staff to complete 1/30/17 at 1:02 p.m., LPN-A should be followed and R39 d assisted as need to do his staff need to try, and try eded, and added R39's teeth e been done." 12/1/17 at 8:49 a.m., the ON) stated oral cares ered in the morning and ts. The DON stated she needed to be offered to but if refused, to another caregiver try. The e to offer oral cares "at least	F 659				

Facility ID: 00866

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 01/31/2018 APPROVED D: 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
245298		245298	B. WING			_	12/01/2017		
NAME OF PROVIDER OR SUPPLIER					STREET ADDRESS, CITY, ST	TATE, ZIP CODE			
THE ESTA	TES AT TWIN RIVERS LI	LC	305 FREMONT STREET ANOKA, MN 55303						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG	IX	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 659	was physical function care impairment and a Staff were directed to assistance of one. R15 was observed on bed watching televisio communicate and had 11/29/17 5:56 p.m. R <sup>2</sup> unshaven with visible 6:49 a.m. R15 was in for the day. He was u facial hair approximat p.m. R15 was in bed visible facial hair and past few days. On 12/ continued to be unsha and left for dialysis at unshaven. During interview on 12/ practical nurse (LPN)- responsible for (R15's assistants (NA's) are whenever he has "lots NA-H who was R15's shaves (R15) when he shave him today but of They do not shave him needed because he p shave him. During this care of him on Thurson not shave him becaus	date 12/1/17 identified R15 ing deficit related to self ability with ADL's can vary. provide personal hygiene 11/28/17 10:08 a.m. in his on, he was unable to d visible facial hair. On 15 was at nursing station facial hair. On 11/30/17 at his wheelchair and dressed unshaven and had visible ely 1/8 inch long. At 12:30 watching television with had not been shaven for the /01/17 at 8:58 a.m. R15 aven with visible facial hair approximately 10:00 a.m. 2/01/17 11:08 a.m. licensed -E stated they were s) shaving and the nursing	F	659					
	one person physical a	shaving. Review of the							

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		MEDICAID SERVICES		OMB NO. 0938-039		
IND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	(X3) DATE SURVEY COMPLETED 12/01/2017			
245298					B. WING	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
THE ESTATES AT TWIN RIVERS LLC						
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLÉTIO	
F 659	documentation from 1 check marks in place	e 21 I1/18/17 to 12/1/17 had for both days and evening personal hygiene was	F 659	)		
F 677 SS=D	nursing (DON) stated click care documenta residents.	01/17 12:35 p.m. director of staff are to follow the point tion when providing cares to or Dependent Residents	F 677	7	1/10/18	
	out activities of daily I services to maintain g personal and oral hyg This REQUIREMENT by: Based on observatio	is not met as evidenced n, interview and document		R39 Activity care plan has been upd reflect current oral care needs and	ated	
	review, the facility failed to ensure oral cares and shaving were offered or provided for 2 of 5 residents (R39, R15) in the sample who were dependent upon staff for assistance with activities of daily living (ADLs). Findings include: R39's diagnoses, as identified on the annual Minimum Data Set (MDS) assessment dated 9/27/17, included cerebral vascular disease (stroke) with left hemiplegia, and identified R39 required extensive assistance of staff to complete ADLs. The MDS also indicated R39 had intact			refusals. Risk and benefits regarding care refusals has been completed an staff will continue to offer assistance. Since survey exit, R39 has been offe assistance with oral care each day pe identified preferences by the clinical s R15 personal hygiene care plan has	red er his staff.	
				updated to reflect current needs and preferences including shaving and sta will continue to assist as indicated. Si survey exit, R15 has been assisted w shaving by clinical staff.	ince	
	ADLs, dated 9/27/16, assistance with dress The care plan, revise	a assessment (CAA) for indicated R39 required ing, grooming and bathing. d 7/12/17, identified R39 oning deficit, but was able to		All residents, including new admits, w continue to be provided care and specifically offered assistance with or care and shaving, as outlined in their individual/comprehensive care plan a	fal	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 01/31/2018 RM APPROVED NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		· /	(X3) DATE SURVEY COMPLETED	
245298		245298	B. WING				2/01/2017
NAME OF PI	ROVIDER OR SUPPLIER		•	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
THE ESTA	TES AT TWIN RIVERS LI	LC			05 FREMONT STREET		
				Α	NOKA, MN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 677	nurse (LPN) checked room. The LPN then milk and jelly to eat in sugar. At 8:22 a.m., L re-check the blood su nursing assistant (NA morning cares. NA-B towels and clothing au routine. NA-B washed placed a lift sling unde lift and with assistance R39 from the bed into seated and adjusted, combed his hair, and anything else he need head. During this mor offer or provide any of R39 she would take h the room carrying the the room. Upon return NA-B transported R35 breakfast, again witho Following breakfast at R39 back to his room wanting to remain in t TV. NA-B adjusted the R39's preference, pla wheel chair and exited provision or offer of ou remained in his chair to eat the noon meal it On 11/30/17, at 12:30 lots of residents to as	<ul> <li>Ip.</li> <li>a.m., a licensed practical R39's blood sugar in his provided R39 with some response to the blood PN-A entered R39's room to gar, and left the room when )-B greeted R39 to begin gathered care supplies, nd began R39's morning d and dressed R39, then er R39. Using a mechanical e of NA-E, NA-B transferred o the wheelchair. Once NA-B groomed R39's face, asked R39 if there was ded, to which R39 shook his ring routine, NA-B did not ral cares for R39. NA-B told into breakfast, then exited bagged, soiled items from n to the room at 8:44 a.m., 9 into the dining room for but offer of oral cares.</li> <li>t 9:43 a.m., NA-B wheeled , where R39 expressed he wheel chair and watch e TV and headphones to ced the call light on the d R39's room. There was no ral cares for R39. R39 until after he was assisted in his room at 12:08 p.m.</li> </ul>	F	677	assessment. All residents were aud and care planned to their individual preference. Since survey exit, all re have been offered assistance with personal hygiene daily including sh and oral care per preferences. Staff including clinical department w re-educated on reviewing, following providing care based on the residen plan of care including personal hyg oral care and shaving, daily and/or residents plan of care. Visual audits will be completed wee 4 weeks, then as needed to ensure specific resident care planned care as: oral care, shaving is being offer daily and/or per the residents prefe Director of Nursing or designee will responsible. QAPI committee will review results provide redirection or change when necessary and dictate continuation completion of this monitoring proce based on compliance date.	sidents aving vill be and at's ene, ber the kly x s such ed rences. be and or	
		sist this morning and did not tating, "I just forgot to offer					

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 01/31/2018 1 APPROVED
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		245298	B. WING			_	12/	01/2017
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE ESTA	TES AT TWIN RIVERS LI	LC			05 FREMONT STREET NOKA, MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	tooth brushing." NA-E dependent upon staff During interview on 1 stated the care plan s should be offered and teeth. LPN-A stated more than once if nee teeth brushing "should When interviewed on director of nursing (Du oral cares should be of evening. The DON sta cares needed to be of refused, staff should n caregiver attempt care A facility document, C identified the purpose procedure was to clea mouth, remove food p to maintain the teeth a condition, to prevent i to keep the resident's The Policy directed st indicated on the resid SHAVING R15's annual Minimun 10/2/17, identified R1 impairment, needed of for all activities of dail rejection of cares. R15's care plan print had a physical function care impairment and st	a also stated R39 was to complete his cares. 1/30/17, at 1:02 p.m., LPN-A hould be followed and R39 assisted as need to do his staff need to try, and try eded. LPN-A added R39's d have been done." 12/1/17 at 8:49 a.m., the ON) stated at a minimum, offered in the morning and ated she expected oral ffered to residents. If reapproach or have another es. Oral Hygiene, dated 2/15, of the [Oral Care] an and freshen resident's oarticles form between teeth, and gums in a healthy nfections of the mouth and lips and oral tissues moist. aff to offer oral hygiene as ent's plan of care. m Data Set (MDS) dated, 5 had severe cognition extensive to total assistance	F 6	77				

Facility ID: 00866

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 01/31/2018 APPROVED D: 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION		(X3) DATE COMP	SURVEY PLETED
		245298	B. WING			_	12/	01/2017
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
THE ESTA	ATES AT TWIN RIVERS LI	LC			305 FREMONT STREET ANOKA, MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	Continued From page assistance of one.		F	677	,			
	his bed watching telev communicate and had 11/29/17, at 5:56 p.m. unshaven with visible 6:49 a.m. R15 was in for the day. He was u facial hair approximat p.m. R15 was in bed visible facial hair and past few days. On 12/ remained unshaven w for dialysis at approxi- unshaven.							
	responsible for (R15's assistants (NA's) are whenever he has "lots NA-H who was R15's shaves [R15] when he shave him today but of They do not shave him needed because he p shave him." During th took care of him on TI did not shave him beo face touched. Review of the facility I one person physical a hygiene which include documentation from 1 identified check marks	se (LPN)-E stated they were s) shaving and the nursing suppose to do this, s of beard." At 11:10 a.m. NA for the day, stated she e is "scruffy." I was going to dialysis come and got him. m every day, only when it is bulls away when we try to his time NA-G stated she hursday (11/30/17) and she cause he doesn't like his Point Of Care form identified assistance with personal ed shaving. Review of the 11/18/17, to 12/1/17, s were in place for both fts which identified personal						

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TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI P	E CONSTRUCTION	(X3) DATE SUR	RVEY	
	CORRECTION	IDENTIFICATION NUMBER:	· ,		COMPLETE		
		245298	B. WING		12/01/2	2017	
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE			
THE ESTA	ATES AT TWIN RIVERS L	LC		305 FREMONT STREET ANOKA, MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE CO	(X5) OMPLETIC DATE	
F 677	Continued From page	∋ 25	F 677				
	(DON) stated staff wa	p.m. director of nursing as to follow the point click when providing cares to					
F 679 SS=D	Activities Meet Intere CFR(s): 483.24(c)(1)	st/Needs Each Resident	F 679		1/1	0/18	
	the comprehensive a and the preferences of program to support re activities, both facility individual activities ar designed to meet the physical, mental, and each resident, encour and interaction in the This REQUIREMENT by: Based on observatio review, the facility fail activities for 2 of 3 resident on staff for	is not met as evidenced n, interview and document led to provide meaningful sidents (R1, R15) who were		R1 and R15 activity care plans ha updated to include goals, participat and interventions to meet identified needs.	tion, I		
	indicated R1 had no s understood and had n depression. The staff activities indicated the important to R1. The total assistance to tra assistance with locon Diagnoses included a	moderately severe interview of family about ere were no activities MDS indicated R1 needed insfer and extensive		A care plan audit was completed o December 22 for all residents who dependent on staff for assistance w activities. Goals and interventions updated as needed to ensure indiv leisure needs are identified for all li residents. Education will continue to provided to the IDT including clinic therapeutic recreation staff on an o basis regarding reviewing, followin providing activities per resident's p care. Therapeutic program director	are vith were idual ike o be al and ongoing g and lan of		

Facility ID: 00866

If continuation sheet Page 26 of 64

		MEDICAID SERVICES	(Y2) MI II TID	PLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· /	3	COMPLETED
		245298	B. WING		12/01/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	P CODE
THE ESTA	ATES AT TWIN RIVERS L	LC		305 FREMONT STREET ANOKA, MN 55303	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE COMPLETION D THE APPROPRIATE DATE
F 679			F 67		
	activities Care Area A 8/23/17, indicated a p	schizoaffective disorder. R1 Assessment (CAA) dated potential problem for 1's inability to communicate		created a weekly particip residents who are depend assistance with activities.	dent on staff for
	and a native languag indicated R1 was una things at this time due communication. Fam	e of Arabic. The analysis able to perform and do many		Audits will be completed weeks of like residents to plans are being followed are being implemented.	ensure care
	developed as R1 was decline due to lack of	licated a care plan was to be s at risk complications and f ability to communicate		The Therapeutic Program designee will be responsi	ible.
	recreation departmen stimulating environme	f stimulation or activities		QAPI committee will revie provide redirection or cha necessary and dictate co completion of this monito based on compliance dat	anges when ntinuation or ring process
	R1's Therapeutic Recreation Evaluation da 8/14/17, indicated R1 was a very social pe attended church and enjoyed traveling. Th assessment indicated R1 was withdrawn, had a poor attention span and did not add how the facility would provide activities or stimulation for R1.	was a very social person, enjoyed traveling. The d R1 was withdrawn, and span and did not address			
	altered socialization of communicate. Goals continue daily indepe and participate in sho Interventions included	11/10/17, indicated R1 had due to the inability to for R1 included R1 would endent activities in his room ort one on one weekly visits. d providing R1 with with evision and other activities.			
	indicated R1 was limi cognitive and physica indicated therapeutic	ation Review dated 11/16/17, ited in his activities due to al status. The review recreation staff and nursing led R1 with readings of the			

If continuation sheet Page 27 of 64

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 01/31/2018 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION		(X3) DATE	
		245298	B. WING			_	12/	01/2017
NAME OF PF	ROVIDER OR SUPPLIER			\$	STREET ADDRESS, CITY, ST	TATE, ZIP CODE	-	
THE ESTA	TES AT TWIN RIVERS LI	LC			305 FREMONT STREET ANOKA, MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 679	as turning on the televal around the facility via during the last quarter activity goals were me R1's activity document following: 9/17 - R1 ha activities were docum family visits, and three were opened for sens had 10 family visits, tw the hall, one time tele on, two prayer visits and During observations of to 2:28 p.m. R1 was have without any music, tel staff aside from requir turning and reposition During interview on 11 member (FM)-A state almost a daily basis, F without any music or twould be nice if he was occasionally even if h activities. FM-A state weather permitting. During observations of to 6:20 p.m. R1 was have on without any music, from staff aside from the turning and reposition During interview on 11	us text) on a tablet as well vision to soccer, wheeling wheelchair and family visits r. The review indicated R1's et. ntation indicated the ad 17 family visits, no other iented. 10/17 - R1 had nine e times the window shades sory stimulation. 11/17 - R1 wice up in the wheelchair in evision with the soccer game	F	679				
	lying in bed and didn't	t have music or a television						

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						O. 0938-039	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	· · · ·	E SURVEY IPLETED	
		245298	B. WING		12/01/2017		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
THE ESTA	ATES AT TWIN RIVERS L	LC		305 FREMONT STREET ANOKA, MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 679	Continued From page 28 on for any stimulation.		F 679				
	through 12:37 p.m. R lights were on withou interaction from staff	on 11/30/17, from 6:54 a.m. 1 was lying in bed. The t any music, television or aside from required care and repositioning) services					
	E stated R1 was alwa participate in any stru terrible for him." NA-E	11/30/17, at 12:24 a.m. NA- ays in bed and did not actured activities. "I feel was not aware of any 1 for any stimulation, other					
	licensed practical nur family visited about e occasionally when far R1 up in a wheelchain him. The facility did n wheelchair unless far requested this, as R1 the one on one when stated R1 had a lack worker talked to famil	mily was here staff would get r, so family could sit with					
	admission a therapeu completed which inclu- stated the compreher annually and quarterl evaluation was comp the only staff member and herself and volum	2/1/17, at 8:09 a.m. director (TPD) stated on utic program evaluation was uded likes and dislikes. TPD nsive assessment was done y a activity participation leted. TPD stated she was r of the activities department nteers provided activities to ated on admission the family					

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HUMAN SERVICES				FC	TED: 01/31/2018 DRM APPROVED NO. 0938-0391
1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>í</i>			(X3) D/	ATE SURVEY DMPLETED
245298	B. WING				12/01/2017
			STREET ADDRESS, CITY, STATE, ZIP CODE		
		:	305 FREMONT STREET		
			ANOKA, MN 55303		
MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)			(EACH CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLETION DATE
9 is rest and really didn't ts. TPD stated she had wnloaded the Quran to done this once or twice. soccer for him once on amily said he liked opened the curtains in and had just e activities with R1 in it was difficult to find R1 with little input from ss with an interpreter speak. TPD stated she ational therapy to help ctivities for R1. A care a day before and the we some more ideas on rences, but added the re taken place earlier and ade attempts even . speech language 1 was discharged from 7/17. The focus of therapy in general, dysphasia of safety in a wheelchair ccessful. Occupation h R1 in activity/stimulation referral from the facility to /17, at 10:27 a.m. l) stated R1 was unsafe for activities, however; s opened and some sort ugh the day. DON stated	F	679			
	EDICAID SERVICES PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298 MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION) S rest and really didn't ts. TPD stated she had wnloaded the Quran to done this once or twice. soccer for him once on amily said he liked opened the curtains in and had just e activities with R1 in t was difficult to find R1 with little input from ss with an interpreter speak. TPD stated she tional therapy to help stivities for R1. A care e day before and the ve some more ideas on rences, but added the re taken place earlier and ade attempts even speech language 1 was discharged from 7/17. The focus of therapy n general, dysphasia d safety in a wheelchair ccessful. Occupation n R1 in activity/stimulation eferral from the facility to /17, at 10:27 a.m. b) stated R1 was unsafe for activities, however; opened and some sort	EDICAID SERVICES         1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MUL A. BUILD         245298       B. WING         MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)       ID PREF TAG         P       F         as rest and really didn't ts. TPD stated she had wnloaded the Quran to done this once or twice. soccer for him once on amily said he liked opened the curtains in and had just e activities with R1 in t was difficult to find R1 with little input from ss with an interpreter speak. TPD stated she tional therapy to help stivities for R1. A care e day before and the ve some more ideas on ences, but added the re taken place earlier and ade attempts even         speech language 1 was discharged from 7/17. The focus of therapy n general, dysphasia d safety in a wheelchair ccessful. Occupation n R1 in activity/stimulation eferral from the facility to         /17, at 10:27 a.m. 0) stated R1 was unsafe for activities, however; opened and some sort ugh the day. DON stated in family to bring in music	EDICAID SERVICES         1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIP A. BUILDING         245298       B. WING         MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)       ID PREFIX TAG         0       F 67         c) s rest and really didn't ts. TPD stated she had wnloaded the Quran to done this once or twice. soccer for him once on amily said he liked opened the curtains in and had just e activities with R1 in t was difficult to find R1 with little input from ss with an interpreter speak. TPD stated she titonal therapy to help tivities for R1. A care e day before and the ve some more ideas on ences, but added the e taken place earlier and ade attempts even         speech language 1 was discharged from 7/17. The focus of therapy n general, dysphasia d safety in a wheelchair coesful. Occupation n R1 in activity/stimulation eferral from the facility to         /17, at 10:27 a.m. ) stated R1 was unsafe for activities, however; opened and some sort ugh the day. DON stated in family to bring in music	DI CAID SERVICES         I) PROVIDER/SUPPLIERCLIA IDENTIFICATION NUMBER:       (2) MULTIPLE CONSTRUCTION A. BUILDING         245298       B. WING         STREET ADDRESS, CITY, STATE, ZIP CODE 305 FREMONT STREET ANOKA, MN 55303         MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)       ID PREFIX TAG         PREVIDENTS INFORMATION)       PREVIDENTS THE ZIP CODE 305 FREMONT STREET ANOKA, MN 55303         MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)       ID PREFIX TAG         9       S rest and really didn't ts. TPD stated she had wnloaded the Quran to done this once or twice, soccer for him once on amily said he liked opened the curtains in and had just a activities with R1 in twas difficult to find R1 with little input from ss with an interpreter speak. TPD stated she tional therapy to help tivities for R1. A care etaken place earlier and ade attempts even         speech language 1 was discharged from 1/17. The focus of therapy n general, dysphasia d safety in a wheelchair coressful. Occupation n R1 in activitystimulation eferral from the facility to         /17, at 10:27 a.m. b) stated R1 was unsafe for activities, however; opened and some sort ugh the day. DON stated n family to bring in music	DICAID SERVICES     OMB       DI PROVIDER/SUPPLER/CLA IDENTIFICATION NUMBER:     (x2) MULTIPLE CONSTRUCTION A BUILDING     (x3) D. C       245298     B. WING     STREET ADDRESS, CITY, STATE, ZIP CODE       305 FREMCONT STREET ANOKA, MN 55303     305 FREMONT STREET ANOKA, MN 55303       MENT OF DEFICIENCIES IDENTIFYING INFORMATION,     PREFIX TAG       CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY     PROVIDER'S PLAN OF CORRECTION USACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY       9     F 679       is rest and really didn't is. TPD stated she had wnloaded the Quran to done this once or twice. soccer for him once on amily said he liked opened the curtains in and had just a activities with R1 in twas difficult to find R1 with little input from ss with an interpreter speak. TPD stated she tional therapy to help tivities for R1. A care day before and the ve some more ideas on ences, but added the e taken place earlier and ade attempts even       speech language 1 was discharged from //17. The focus of therapy n general, dysphasia d safety in a wheelchair crossful. Occupation n R1 in activity/stimulation eferral from the facility to       /17, at 10:27 a.m. ) stated R1 was unsafe for activities, however; opened and some sort ugh the day. DON stated n family to bring in music

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	
		245298	B. WING			12/	01/2017
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE ESTA	TES AT TWIN RIVERS L	LC			305 FREMONT STREET ANOKA, MN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)		(X5) COMPLETION DATE
F 679	further stated the nursi instructed to provide a R1 throughout the da The facility policy The 7/09, provided a polic mission to promote di person and we offer a interest to all clients." implementation stater calendar is developed Recreation and distrit did not include any fu R15's annual Minimut 10/2/17, identified R1 impairment, needed e for all activities of dail preferences were ide MDS identified R15's newspaper, music, ar group of people, impo going outside and relivery with of show Ocear with yes and no responses dining room waiting for In an interview on 11/ member (F)-A stated basketball, tennis as fan and knew a lot of sports, and his favorit then football. F-A state	sing assistants had not been any structured activities for y. erapeutic Recreation dated by statement " It is our gnity and worth of each a variety of activities of A policy interpretations and ment of "A monthly activities d by the Therapeutic buted to client." The policy rther information. Im Data Set (MDS) dated 5 had severe cognition extensive to total assistance y living, and activity ntified by the resident. The preferences of books, nimals, news, being with ortant favorite activities, gious services were all not In 11/28/17, at 10:08 a.m. ng, the television was on ns 11, able to communicate onse but was inconsistent . At 12:05 p.m. he was in the or his meal to be served. 28/17, 4:15 p.m. family	F	679			

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		ID HUMAN SERVICES MEDICAID SERVICES				INTED: 01/31/2018 FORM APPROVED IB NO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING			) DATE SURVEY COMPLETED
		245298	B. WING			12/01/2017
NAME OF PI	ROVIDER OR SUPPLIER		STF	REET ADDRESS, CITY, STATE,	ZIP CODE	
			305	FREMONT STREET		
THEESTA	TES AT TWIN RIVERS L	_C	AN	OKA, MN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 679	Continued From page	÷ 31	F 679			
	these. They were uns activities, they usually	sure if R15 attended any / don't see him in activities out think the facility does				
	therapeutic program of participated in bingo, for movies. He was lib but liked the MN Wild She was unsure what but would check. At 6 maintenance director brought from home. T channels on it, now th	1/29/17, at 12:41 p.m. director (TPD) stated R15 social events, and came out imited because of dialysis, hockey and MN Vikings. t his assessment identified i:58 p.m. TPD stated the fixed R15's television, he The television only had five hat it was reprogrammed he hannels the facility offered e sports channels.				
	the nurses station wa had a Twins t-shirt on (LPN)-D stated R15 li R15 smiled at LPN-D room either by the nu of the hallway until 8: brought to his room to activities occurring du R15 went to bed NA- an evening program, sports channel. During observation or was waiting for his br NA-F was feeding hin a.m. R15 was placed liked soap operas, ca seen him in bingo but television. NA-G was channels had been re	n 11/29/17, at 5:56 p.m. at iting for his medication and it Licensed practical nurse iked the MN Vikings and . R15 remained out of his rsing station or in the middle 04 p.m. when he was o go to bed. There were no uring this time of day. Once A turned the television on to but did not turn the TV to a n 11/30/17, 7:48 a.m. R15 eakfast and at 8:08 a.m. n without difficulty. At 8:45 in bed and NA-G stated he rtoons and sports. She has a not a lot he liked to watch unaware R15's television eprogrammed so R15 could urned the television on, and				

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			0.00			10.0938-03	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · ·	TE SURVEY MPLETED	
		245298	B. WING		12/01/2017		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
THE ESTA	TES AT TWIN RIVERS L	LC	305 FREMONT STREET ANOKA, MN 55303				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
F 679	Continued From page	e 32	F 67	9			
		ook for a sports channel.					
		ied on a news program.					
		television and left the room.					
	-	room until the lunch meal					
	was served, and had	the same television station					
	on. Staff made no att	empts to change the					
	television station to a	sports channel for R15.					
		plan print date 12/1/17, did					
	-	tion about activity goals or					
	participation.						
		MHM Activity Participation					
		7, identified under the					
	attendance and partic						
		roup activities infrequently dining room, snack cart and					
		lent enjoyed independent					
	activities such as wat						
		alysis three times a week					
		ation. Resident's favorite					
		ied as preferring visits from					
		ent activities. Resident					
	enjoyed watching spo	orts. Resident was proud of					
	being a military veter	an. The activity plan review					
	-	nained appropriate/current					
		l was met and interventions					
	were effective in read						
	The facility had a Leis	-					
		ed R15 was interested in					
		n parenthesis Christian, rts which include Vikings,					
		s computer games/lesson,					
		and animals. The form also					
		bies of going out to eat,					
	Frisbee gold, throwin						
		ion forms from August 2017,					
		lentified activities that R15					
	was involved in:						
	-	TV/radio: 9 days and was					
	hospitalized 13 days		1			1	

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		MEDICAID SERVICES				O. 0938-039		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	· · ·	E SURVEY IPLETED		
		245298	B. WING		12	2/01/2017		
NAME OF P	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE	Ξ			
THE EST	ATES AT TWIN RIVERS L	LC		305 FREMONT STREET ANOKA, MN 55303				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE		
F 679	9/17: meals 19 days; TV/radio: 19 days; ex 1 day 10/17: meals 22 days 22 days, spiritual visit participation in games days and social even 11/17: meals 18 days day; TV/radio 18 days day; TV/radio 18 days Refused games 4 day events 1 day. Review of the data id his days watching tele involved in 13 days of spiritual visits, social August to November During interview on 1 stated they did a qua participation before h annual evaluation und On a monthly basis h and the check mark fi meals and there was counted as an activity was limited due to his week. TPD was unaw Request Form, she d used in the past. R15 activities, but did hav they have not incorpo program, since she w facility that did activiti needs to look into this of what R15's activity measured. She also	conversation 2 days, tercise 1 day; spiritual visits s; social events 2 days; TV ts 4 days. Refused s, 4 days; currents events; 2 t 1 day s, music 1 day; social event 1 s, spiritual visits 3 days. ys and refused current entified R15 spent most of evision, and was only f other events that included events, and exercise from 2017, 111 days. 2/1/17, 11:41 a.m. TPD rterly review of his activity is care conference, and an der section F of the MDS. is participation was tracked, or meals means he was at music on which was y for R15. She stated R15 is dialysis being three times a vare of the facility Leisure id not know this had been is received no 1:1 visits from e pastoral visits. TPD stated orated 1:1 into R15's vas the only person in the les for R15. She was unsure goals were or how this was stated she did not tell other els being programmed to	F 675					

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		ND HUMAN SERVICES MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-039
TATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		245298	B. WING		12/01/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•
THE ESTA	TES AT TWIN RIVERS L	LC	305 FREMONT STREET		
				ANOKA, MN 55303	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE COMPLÉTIO
F 679	Continued From page	e 34	F 6	79	
	sports.		_	-	
	Although R15 was de	ependent upon staff, and was			
		participate in activities			
		ce, the facility had not			
		nensive assessment of or care plan interventions to			
	meet those needs.				
F 686 SS=D		event/Heal Pressure Ulcer (i)(ii)	F 6	86	1/10/18
	§483.25(b) Skin Integ	nrity			
	§483.25(b)(1) Pressu				
		ehensive assessment of a			
	resident, the facility n				
	()	s care, consistent with			
		ds of practice, to prevent does not develop pressure			
	-	ividual's clinical condition			
	demonstrates that the	ey were unavoidable; and			
		essure ulcers receives			
	-	and services, consistent			
	with professional star	vent infection and prevent			
	new ulcers from deve	-			
		Γ is not met as evidenced			
	by:				
		on, interview and document		Resident R15 care plan has bee	
	current pressure ulce	ed to ensure residents with ers were turned and		specifically updated to reflect ev repositioning. Clinical staff have	-
		or 1 of 3 residents with		re-educated.	
	pressure ulcers.				
				All residents, including new adm	
	Findings include:			continue to be provided care and	
	R15's annual Minimu	m Data Set (MDS) dated		repositioning as care plan reflect residents skin plan of care, inclu	
		5 had severe cognition		repositioning schedules have be	
		extensive to total assistance		audited as of December 26 and	
		ly living, was at risk for		specific positioning frequencies	

Event ID: 23SE11

Facility ID: 00866

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		MEDICAID SERVICES	(X2) MUITIP	E CONSTRUCTION		<u>NO. 0938-039</u> TE SURVEY		
	CORRECTION	IDENTIFICATION NUMBER:	, <i>,</i>			MPLETED		
		245298	B. WING			2/01/2017		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA		2/01/2011		
				305 FREMONT STREET				
THE ESTA	ATES AT TWIN RIVERS L	LC		ANOKA, MN 55303				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE EFICIENCY)	(X5) COMPLETION DATE		
F 686	Continued From page	e 35	F 68	6				
		levelopment, and had a	1 00	care needs to preve	nt and/or heal skin			
		Partial thickness loss of		impairments/ulcers,				
		a shallow open ulcer with a		assessments.				
	red-pink wound bed).	. The MDS indicated R15						
	received treatments of				be re-educated on all			
		and was on a hydration		resident's current sk				
	program and PU trea	tment program.			ng schedules and to			
	During continuous of	oservation on 11/29/17, from		follow the resident s	pecific care plan.			
		n., R15 was not repositioned		Audit of repositionin	g will be done weekly			
		R15 had just finished his		x 4 weeks and then				
		as sitting at the nursing						
	-	ers while waiting for his		Director of Nursing	or designee will be			
		d practical nurse (LPN)-D		responsible.	-			
	was preparing the me	edications and talking about						
		p.m. R15 remained sitting in		QAPI committee will				
	-	he nurse and remained there		provide redirection of	-			
		LPN-A wheeled R15 to his		necessary and dicta				
		administration via tube		completion of this m	• •			
	U U	eled back to the nursing vithout being repositioned.		based on compliance	e date.			
		heelchair at the nursing						
		. when asked by nursing						
		wanted to go to bed. R15						
		-A wheeled R15 half way						
		d left him in the hallway.						
	-	nanical lift into R15's room						
		hile R15 remained sitting in						
		o.m. he was wheeled back to						
	•	nd left. He remained there he was again wheeled half						
		y and left in the hallway. He						
		and left in the nativaly. He						
		ents and passing out evening						
	-	registered nurse (RN)-A						
	wheeled R15 into his	room and motioned NA-A to						
		bed. With a mechanical lift						
	-	ided personal cares. R15						
	was incontinent of bo	wel and bladder his buttocks						

Facility ID: 00866

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CENTER	-	D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA				FORM	0: 01/31/2018 1 APPROVED 0: 0938-0391
	CORRECTION	IDENTIFICATION NUMBER:				· /	LETED
		245298	B. WING		_	12/	01/2017
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
THE ESTA	TES AT TWIN RIVERS LI	_C		05 FREMONT STREET ANOKA, MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	approximately .2 cm i surrounding the area. incontinent of small a movement. RN-A state very small and had be During interview follow NA-A stated R15 was "4:00 ish", then stated around 7:00 p.m., the p.m.", more than 4 ho he should be turned a hours. Review of the facility's which were used by th provide care and is pa- identified R15 needed every 2 hours, but the frequently R15 needed repositioned even tho pressure ulcer. R15's care plan print was at risk for PU dev of stage 3 and 2 press stage 2 PU on his coo conduct weekly skin a pressure reducing cus apply barrier cream a and turn and repositio assessment. R15's pressure ulcer dated 10/13/17, indica to right gluteal, seen f treatment per order, a was incontinent of bor assistance with turning	an indentation on his was located which was in size with pink tissue NA-A stated he was mount of urine and bowel ed the PU looked good, was een improving. Wing cares at 8:46 p.m. last repositioned around the was repositioned in stated it was "around 4:00 urs ago. She further stated and repositioned every two is undated Team 4 sheets, he nursing assistants to art of the facility care plan, t assistance with toileting ere was no indication of how d to be turned and ugh he had a current date 12/1/17 identified R15 velopment and had a history sure ulcers with a current ccyx. Staff was directed to assessments, provide shion in chair, and bed, fter incontinence, toilet plan on schedule per care area assessment ated R15 had a stage 2 PU by wound nurse practitioner, iir mattress to bed. Resident wel and bladder, needed g and repositioning. Braden to determine risk level for	F 686				

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 01/31/2018 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE	
		245298	B. WING			_	12/	01/2017
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE ESTA	TES AT TWIN RIVERS LI	_C			05 FREMONT STREET NOKA, MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686 F 688 SS=D	repositioned per asse this was not identified Review of R15's week 11/28/17, identified R on his coccyx was imp the note identified the centimeters in size at R15's right lower butto During interview on 12 stated R15's care plan turning and reposition be. During interview on 12 above information wa of nursing, who indica turning and reposition Increase/Prevent Dec CFR(s): 483.25(c)(1)- §483.25(c) Mobility. §483.25(c)(1) The fac resident who enters the range of motion does range of motion unless condition demonstrate of motion is unavoidad §483.25(c)(2) A reside motion receives appro- services to increase re- prevent further decrease	the care plan and R15 was to be turned and ssment, the frequency of dy skin notes from 10/17, to 15 had a stage 2 PU located proving in size. On 11/28/17, PU measured .2 and staff were to monitor bocks near his brief line. 1/30/17, at 2:00 p.m. LPN-E in was not specific for a ing schedule but it should 2/1/17, at 12:35 p.m. the s reviewed with the director ited they needed to follow a ing schedule for (R15). crease in ROM/Mobility (3) illity must ensure that a he facility without limited not experience reduction in is the resident's clinical es that a reduction in range ble; and ent with limited range of		686				1/10/18

Facility ID: 00866

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB	NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		E CONSTRUCTION	· · ·	TE SURVEY MPLETED
		245298	B. WING			1	2/01/2017
NAME OF P	ROVIDER OR SUPPLIER	•		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE ESTA	TES AT TWIN RIVERS L	LC	305 FREMONT STREET ANOKA, MN 55303				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)			BE	(X5) COMPLETION DATE
F 688	Continued From page	e 38	F	688			
	assistance to maintai the maximum practic reduction in mobility i This REQUIREMENT by: Based on observatio review the facility fails and a nursing rehabil maintenance program the sample who had Findings include: R15's annual Minimu 10/2/17, identified R1 impairment, needed for all activities of dai lower extremity impai cares and there was rehabilitation program Review of the facility sheets (form that iden for each resident), un ADL's were "Right ha in AM [morning]." The	n for 1 of 2 resident (R15) in limited range of motion. m Data Set (MDS) dated, 5 had severe cognition extensive to total assistance ly living (ADL's), no upper or irments, had no rejection of no mention of a nursing			Resident R15 is provided a functional range of motion program as recommended by therapy to include a splint to be applied at bedtime and removed in the morning. R15 care pla updated to reflect range of motion program, splint use, and activity goals participation and interventions implemented to meet identified needs All residents will continue to be offered any maintenance program as recommended by therapy. Audit of therapy record and nursing has been completed to ensure that they are included in the plan of care. Nursing s will follow recommendation and re approach and/or document refusals. Process has been implemented to improve therapy to nursing communication. Nursing will continue provide proper ROM.	n , d	
	was wheeled into his (RN)-A and motioned help assist with perso R15 face, while wash	n 11/29/17, at 8:04 p.m. R15 room by registered nurse I nursing assistant (NA)-A to onal cares. NA-A washed ning his face R15 was turning ing his left hand to push			Education will be completed with thera and clinical staff regarding the newly revised communication process to inc nurse manager initially receiving all therapy communications and ensuring plan of care is developed and followed	lude	
	NA-A away. R15 did which continued to la attempts to move his	not raise his right hand y in his lap. R15 made no right hand. RN-A gave R15 old with his left hand and			Audit will be completed by director of nursing or designee weekly x 4 and a needed. During this audit, nursing will	S	

Facility ID: 00866

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		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	OMB NO. 093 (X3) DATE SURV	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	COMPLETED	)
		245298	B. WING		12/01/20	)17
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP C	ODE	
THE ESTA	TES AT TWIN RIVERS L	LC		305 FREMONT STREET ANOKA, MN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COM THE APPROPRIATE	(X5) IPLETION DATE
F 688	Continued From page	e 39	F 68	38		
	on his incontinent brie move his right hand w lap. After cares were RN-A and NA-A left th attempts to provide a they place a splint on interview at 8:46 p.m did not have any nurs a splint that went on a shift was responsible During observation of was up and dressed stated she got R15 u cares. She had to ho pushed them away d R15 was supposed to hand, but he did not b she arrived to work. Review of R15's Occ dated 9/26/16, identiff hemiparesis (paralys) trace movement of hi	n 11/30/17, at 6:49 a.m. R15 ready for the day. NA-F p and provided personal ld his left hand because he uring cares. NA-F stated b have a splint on his right have it on this morning when upational Therapy (OT) note,		collaborate with therapy an recommendation are currer point of care, and nursing a guides. QAPI committee will review provide redirection or chan necessary and dictate cont completion of this monitorir based on compliance date.	nt on care plan, assistance are v results and ge when inuation or ng process	
	when should flexion p Review of a Therapy 10/31/16, identified R	ed with verbalization of pain past 140 degrees. Communication form dated, t15 to apply right hand splint remove to clean hand with				
	The facility Therapy ( 12/1/16, identified fur program (FMP) provi	Communication form, dated nctional maintenance de ROM to right upper , five repetitions to shoulder,				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE	
		245298	B. WING _			12/	01/2017
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
THE ESTA	TES AT TWIN RIVERS L	LC			5 FREMONT STREET NOKA, MN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 688	Continued From page	e 40	F 6	688			
	identified nursing to c	ight hand splinting schedule					
	9/25/17, identified bila passive range of moti limits. Limited range of hemiparesis/brain inju was on a functional m	upational therapy note, ateral upper extremity ion (PROM) within functional of motion related to ury. Nursing reports R15 naintenance program (FMP) om previous therapy in					
		note dated 10/3/17, in place and to continue the t changed or declined.					
	problem with physical mobility impairment, t	a date 12/1/17, identified a I functioning related to but did not address the use or any restorative nursing					
	record (TAR) from 9/1	treatment administration 17, through 11/17, did not motion, or any hand splint ne record.					
	occupational therapy	2/1/17, at 8:13 a.m. certified assistant (COTA)-A stated t15 had any FMP PROM any hand splints.					
	stated she has never resident. He had blue	2/1/17, at 11:23 a.m. LPN-E seen a hand splint on the boots but no splints and (R15) received any range of					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		E CONSTRUCTION	(X3) DATE	
		245298	B. WING			12/	01/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE ESTA	TES AT TWIN RIVERS L	LC			05 FREMONT STREET ANOKA, MN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 688	motion (ROM). She s directions on the med or care plan for the ha During interview on 1 stated the resident ha wear it anymore. NA- hand splint, and went the splint in the top dr wore the splint at nigh not have it on, nor di (12/28/17) morning w Frequently he did not worked. Evenings are when he went to bed, occur. During interview on 1 Physical Therapy (DF therapy notes for R15 documentation, R15 v maintenance program The last therapy note was still on a FMP wit right hand. DPT state created a FMP and m program. If they had of change the FMP they therapy. There was n splinting program had still be receiving this. On 12/1/17, at 12:35 (DON) stated she was hand splint, but did no PROM program and n DON reported R15's of right hand splint or the	tated there were no lication or treatment records and splint or ROM. 2/1/17, 11:27 a.m. NA-H ad a hand splint, but did not -I stated R15 had a right into his room, and located rawer of his night stand. He ht, but this morning he did d he have it on on Tuesday hen she took care of him. have it on when she e suppose to place it on him but this frequently did not 2/1/17, 12:13 p.m. Director PT) stated he reviewed the 5. Based on the notes and	F	6888			

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			0.00			NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G		DATE SURVEY
		245298	B. WING			12/01/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE	
			305 FREMONT STREET			
THE ESTA	ATES AT TWIN RIVERS L	LC		ANOKA, MN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCEE	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 698 SS=D			F 69	98		1/10/18
	require dialysis receiv with professional star comprehensive perso the residents' goals a This REQUIREMENT by: Based on observatio review the facility failed dialysis center had co monitoring dialysis si the survey sample with Findings include: R15's annual Minimu 10/2/17, identified R1 impairment, needed of for activities of daily I for rejection of cares. identified a diagnosis and receiving hemod R15 was observed on at 2:45 p.m. and had from hemodialysis. A assistant (NA)-A and were assisting R15 w bedtime. NA-A stated on the resident every This prevents him fro catheter tubing which out. R15 had a centra	T is not met as evidenced on, interview and document ed to ensure the facility and bordinated dialysis care for te for 1 of 1 resident (R15) in ho received hemodialysis. In Data Set (MDS) dated, 15 had severe cognitive extensive to total assistance iving and had no behaviors The face sheet, undated, of end stage renal disease		R15 dialysis plan of ca updated to reflect incre- site monitoring during of assistants and every 4 completion of changing needed to prevent furth The Estates at Twin Ri follow dialysis recomm surrounding the approp use with R15 to prever current dialysis centers called on 12/29/17 with concerns. Bi-weekly ca with R15's dialysis cent to ensure sustainment implemented. All residents, including dialysis treatment will the dialysis center. Ver will be made routinely dialysis centers should in service occur. Comm worksheets that includ assessment and dialys will be sent with all res	eased daily dialysis care by the nursing hours with the g the dressing as her dislodgement. wers will continue to lendation priate dressing to nt infection. All s being used were n no identified alls have been sit up ther and the facility of the solutions admits, with continue to be be coordinated with rbal communication with all other I concerns or gaps nunication e pre and post sis updates/orders,	
	catheter were wrappe	avicle, the ports of the ed with kerlix gauze. The approximately 4 inch by 4		will be sent with all res dialysis and will be rev return to the facility. Al	iewed upon their	

Facility ID: 00866

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245298	B. WING		12/01/2017
NAME OF PR	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE	
THE ESTA	TES AT TWIN RIVERS I	LC		305 FREMONT STREET ANOKA, MN 55303	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLÉTIO
F 698	Continued From pag	le 43	F 698	3	
F 098	inch clear dressing of edge of the dressing of 1 inch but the dressi While NA-A and RN- cares, they encourage animal with his left h hand during cares. F the dressing was roll stated the dressing of he went to dialysis. Review of R15's faci record (TAR) for Nov 2017, directed staff t Central Venous Cattle each shift to ensure dressing falls off, use mask on patient and intervention was star Review of the Dialys Form from March to the following: 11/13/17 "Patient rer reapply if needed." 10/18/17 "Please ma covered at all times.	wer the site. The bottom had rolled up approximately ng was still intact to the skin. A, were assisting R15 with ged him to hold a stuffed and or they held R15 left RN-A, confirmed the edge of led up but still intact. NA-A got changed daily and when lity treatment administration vember 2017 through March to check dressing on R15's heter (CVC) left upper chest dressing is over the site. If e sterile technique with a nurse. Do not get wet. This	F 698	<ul> <li>have again been made aware of thi continued process. All resident's dia plan of care have been audited and monitoring needs and care have be identified with appropriate intervent place.</li> <li>Re-education will be provided to the clinical team on overall dialysis care care and daily dialysis procedures including retrieval of communication worksheet. Nurses have been re-educated on ensuring R15 has h dialysis site properly dressed per th orders, remain with a shirt on and h fidget relief items in his hands to pro- self removal/tampering of the dress needed.</li> <li>DON and/or designee will monitor p and ensure proper communication of dialysis. If communication form is n- out by dialysis center, attempts will made to contact to obtain informatic ensure continuity of care. Dialysis s monitoring to include random visual inspections of R15. Completion of communication worksheet by dialys center and facility audits will be con</li> </ul>	alysis I site seen ions in e e, site n h is ne colding event ing as process with ot filled be pon to site I
	dressing." The Fresenius Media identified under sign [patient] came to dia bleeding."	removing dialysis site cal Care form, undated, ificant events at dialysis, "Pt lysis cath [catheter] ace catheter drsg [dressing]		weekly x 4 weeks. QAPI committee will review results provide redirection or change when necessary and dictate continuation complete of this monitoring process based on compliance date.	or

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DA	TE SURVEY			
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · ·	MPLETED			
		245298	B. WING		1	2/01/2017			
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE					
THE EST	ATES AT TWIN RIVERS L	LC		305 FREMONT STREET ANOKA, MN 55303					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE			
F 698	5/15/17 "Site should I sterile dressing (should loose, it must be cover 3/29/17 "I sent cath d apply sterile technique and staff. We will try it will stick better. Do During interview on 1 Fresenius Dialysis RI at the dialysis center resident had problem various sites, so it wa home to monitor R15 stated R15 comes from dialysis center, with H either not on, or not s stated, today his dress R15 was pulling at it. communicated with th continued to be an or communication form the dialysis center an coordination and corr On 12/1/17, at 11:08 (LPN)-E stated R15's checked it before he dressing comes off, w She has never had to dressing before, and from the NA about his During interview on 1 and NA-I both stated morning, and noticed line was peeling and only area that was sti	be always be covered with ild it inadvertently come ared.)" Iressing w [with] if falls off. e with mask on pt [patient] other dressing today to see if not get wet." 2/1/17, at 10:46 a.m. the N-E stated R15 was currently for a run. RN-E stated the s with infections at other as important for the nursing 's central line dressing. She om the nursing home to the his central line dressing, accured very well. RN-E asing was just hanging and This has been ne nursing home but it ngoing problem. They used a that was sent to and from d nursing home for munication needs. a.m. licensed practical nurse a dressing was on when she left this morning. If the ve clean it and replace it. o replace R15's dialysis site had not heard any concerns a dressing this morning. 2/1/17, at 11:27 a.m. NA-H they took care of R15 this the dressing on his central almost off. NA-I stated the cking to his skin was an tt size area just around the	F 698						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/31/2018 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	CONSTRUCTION		(X3) DATE	
		245298	B. WING		_	12/	01/2017
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE	-	
THE ESTA	TES AT TWIN RIVERS LI	LC		05 FREMONT STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 698 F 757 SS=D	director of nursing on stated they needed to The Long Term Care Services Agreement of the parties will mutual for the development a resident's care plan re dialysis services. The for the interchange of necessary for the care inform the ESRD Dial for the oversight of dia Drug Regimen is Free CFR(s): 483.45(d)(1)- §483.45(d) Unnecess Each resident's drug p unnecessary drugs. A drug when used- §483.45(d)(1) In exce duplicate drug therap §483.45(d)(2) For exc §483.45(d)(3) Withou use; or §483.45(d)(5) In the p consequences which reduced or discontinu §483.45(d)(6) Any co	n was discussed with the 12/1/17, at 12:30 a.m. who o monitor this more closely. Facility Outpatient Dialysis effective 4/1/2016 identified lly develop a written protocol and implementation of a elative to the provision of a nursing facility will provide information useful or e of the resident and will lysis Unit who is responsible alysis services. e from Unnecessary Drugs -(6) ary Drugs-General. regimen must be free from An unnecessary drug is any essive dose (including y); or cessive duration; or t adequate monitoring; or t adequate indications for its presence of adverse indicate the dose should be	F 698				1/10/18

Facility ID: 00866

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		MEDICAID SERVICES	(X2) MULTI	PLE CONSTRUCTION		<u>IO. 0938-039</u> TE SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	· · ·	G	· · ·	MPLETED
		245298	B. WING		1	2/01/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
THE ESTA	ATES AT TWIN RIVERS L	LC		305 FREMONT STREET ANOKA, MN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 757	section. This REQUIREMENT	e 46 is not met as evidenced	F 7	57		
	facility failed to ensur	and document review the e adequate monitoring was resident (R2) who received ring.		Resident R2 had blood glu added to order to prompt n documentation of levels.	ursing	
	Finding include:	n Data Set (MDS) dated		All residents, including adm proper documentation of or signs or medication adminis Medication reconciliation fo	dered vital stration.	
	11/17/17, identified R	2 had moderate cognitive nosis of diabetes (high blood		has been completed. Nurses will be re-educated		
		an Order Summary Report		transcribing with return den the ability to successfully tra- orders or more if needed.	nonstration of	
	units/milliliters (long a every morning and a	acting insulin) subcutaneous sliding scale of insulin		All orders will continue to be		
	glucose levels. The s	sulin) based on R2's blood cale ranged from 2 unit of od glucose of 150-199		checked by a licensed nurs reconciliation will continue t admit/re-admit and as need	to occur upon	
	milligram/deciliter (mo	g/dl) up to 10 units for blood 50 mg/dl. Review of R2's lab		changes.		
	report dated 11/1/17, (measures glycated h (normal range 4-5.6).	nemoglobin) was high at 6.2,		Medication administration re- treatment administration re- audited for accuracy of order and appropriate documenta	cord will be er transcription	
	R2's blood glucose m four times a day to or	dated 11/21/17, identified ionitoring was changed from ince a day due to resident		supplementary data includi levels and values (ie blood blood glucose, vital signs, e	pressure, etc.) on 5	
	blood glucose levels morning glucose leve	lso identified to monitor R2's every morning and if R2's Is are less 75 mg/dl and dl to contact the physician.		random residents weekly x needed thereafter. Random TAR audits will remain on a basis as needed.	n MAR and	
	and treatment record	November 2017 medication s identified R2's blood ing at 7:00 a.m. The form		DON and/or designee will b party.	e responsible	

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TATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	E CONSTRUCTION	(X3) DAT	E SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CON	IPLETED
		245298	B. WING		12	2/01/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
THE ESTA	TES AT TWIN RIVERS L	TC		05 FREMONT STREET ANOKA, MN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 757	Continued From pag	e 47	F 757			
		s with staff initials. There		QAPI committee will review res	ults and	
		what R2's blood glucose		provide redirection or change w		
	levels were from 11/2	21/17 until current 12/1/17.		necessary and dictate continua		
	During interview on 2	11/30/17, at 1:51 PM Trained		completion of this monitoring pl based on compliance date.	ocess	
	-	(TMA)-A stated they check				
		evels every morning, and				
		od glucose levels were				
	•	ange of physician orders on ted she can check R2's				
		ne to see what the levels				
	-	Review of R2's machine				
		es of 12/1 and 12/4. The				
		with accurate dates and o determine what R2's blood				
		A-A stated it was important				
		because the physician				
		l if R2's blood glucose level and lower than 75 mg/dl.				
	On 11/30/17, at 1:58	PM licensed practical nurse				
		erson who changed the				
		ould have added an area in				
		n so blood glucose levels nonitor. The nurses should				
		this concern to each other.				
		11/30/17, at 2:11 p.m. health				
		C)-A reviewed R2's blood				
	• •	ystem and stated any nurse omputer system and should				
		noted this was missing. R2's				
	-	not monitored for 10 days.				
F 880 SS=F	Infection Prevention CFR(s): 483.80(a)(1)		F 880			1/10/18

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/31/2018 APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE	
		245298	B. WING			12/	01/2017
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
THE ESTA	TES AT TWIN RIVERS LI	_C			5 FREMONT STREET NOKA, MN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	infection prevention a designed to provide a comfortable environm development and tran- diseases and infection §483.80(a) Infection p program. The facility must estal and control program ( a minimum, the follow §483.80(a)(1) A syste reporting, investigatin and communicable di staff, volunteers, visito providing services und arrangement based u conducted according accepted national sta §483.80(a)(2) Written procedures for the pro- but are not limited to: (i) A system of surveil possible communicable infections before they persons in the facility; (ii) When and to whor communicable diseas reported; (iii) Standard and tran- to be followed to prev (iv)When and how iso resident; including bur (A) The type and dura	nd control program a safe, sanitary and bent and to help prevent the asmission of communicable ns. prevention and control blish an infection prevention (IPCP) that must include, at <i>v</i> ing elements: em for preventing, identifying, g, and controlling infections seases for all residents, ors, and other individuals der a contractual pon the facility assessment to §483.70(e) and following ndards; estandards, policies, and ogram, which must include, lance designed to identify ble diseases or c can spread to other ; m possible incidents of se or infections should be asmission-based precautions ent spread of infections; blation should be used for a t not limited to:	F 84	80			

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-039		
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245298	B. WING		12/01/2017		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
THE ESTA	TES AT TWIN RIVERS LI	LC		305 FREMONT STREET ANOKA, MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	REFIX (EACH CORRECTIVE ACTION SHOULD BE			
F 880	<ul> <li>(B) A requirement tha least restrictive possil circumstances.</li> <li>(v) The circumstances must prohibit employed disease or infected sk contact with residents contact will transmit th (vi)The hand hygiene by staff involved in din §483.80(a)(4) A syste identified under the fa corrective actions tak</li> <li>§483.80(e) Linens. Personnel must hand transport linens so as infection.</li> <li>§483.80(f) Annual rev The facility will condu IPCP and update thei This REQUIREMENT by: Based on observatio review the facility faile handwashing and glo for 1 of 5 residents (R cares. In additional th management program legionella, which had residents, along with</li> <li>Findings include:</li> </ul>	t the isolation should be the ble for the resident under the s under which the facility ees with a communicable cin lesions from direct a or their food, if direct he disease; and procedures to be followed rect resident contact. The for recording incidents acility's IPCP and the en by the facility. le, store, process, and to prevent the spread of riew. ct an annual review of its r program, as necessary. T is not met as evidenced an, interview and document ed to ensure proper ve usage was implemented (15) observed for personal e facility lacked a water in for the prevention of the potential to affect all 43 staff and visitors.	F 880	NA-A was re-educated on infection control in relation to hand washing and glove use, with hand hygiene skill demonstrated. The facility has establis a water management program for prevention of legionella. R15 and all residents, including admits are receiving appropriate personal car with the use of appropriate PPE to pre- the spread of infections based on universal precautions. All clinical staff and other pertinent	shed s, es		

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STATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
ND PLAN OI	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		245298	B. WING		12/01/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
THE EST	ATES AT TWIN RIVERS LI	LC		305 FREMONT STREET ANOKA, MN 55303	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETIO
F 880	11/29/17, at 8:04 p.m (RN)-A wheeled R15 nursing assistant (NA bed. NA-A and RN-A mechanical lift to tran into bed. Once in bed placed gloves on and washcloth. NA-A rem product, which was so R15's perineal area. S and without washing b pair of gloves and cor with a disposable clot movement which NA- NA-A used the same incontinence brief on adjusting his gown, bu on a pillow without rei NA-A continued with the placed heel protectors soiled clothing and op She washed R15's bas the drawer of R15's n soiled gloves. During interview on 1 R15's cares were con she did not change he hands between glove The above information director of nursing on additional information Review of the facility Handwashing, undate Indication for Hand H identified as; before a resident, after contact	. when registered nurse into his room and motioned .)-A to assist the resident to assist R15 using a sfer him from the wheelchair d NA-A removed the sling washed R15's legs with a oved R15 incontinent oiled with urine then washed She removed her gloves her hands donned a new thinued to provide peri care th. R15 had a small bowel A cleaned. When finished soiled gloves and placed an R15, touching R15's pillow, edding and placed his feet moving the soiled gloves. the same soiled gloves and s on R15, picked up R15's bened the bathroom door. asin and placed the basin in ightstand, then removed the 1/29/17, at 8:46 p.m. after npleted, NA-A was unaware er soiled gloves or wash her usage. n was discussed with the 12/1/17, at 12:30 a.m. , no was provided. policy entitled, ed, identified procedure B: ygiene/Handwashing were and after direct contact with	F 880	<ul> <li>departments will receive re-educat proper use of personal protective equipment, including glove use to infection and demonstrate hand hy competency. All staff will received education on the water manageme program to prevent legionella.</li> <li>Audit of resident personal cares wi use of appropriate PPE will be con weekly x 4 weeks and as needed thereafter.</li> <li>Director of Nursing or designee will responsible.</li> <li>QAPI committee will review results provide redirection or change when necessary and dictate continuation completion of this monitoring process based on compliance date.</li> </ul>	prevent rgiene ent th the npleted I be and n

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 01/31/2018 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		E CONSTRUCTION		(X3) DATE SUI COMPLET	
		245298	B. WING			_	12/	01/2017
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
THE ESTA	TES AT TWIN RIVERS LI	_C			805 FREMONT STREET ANOKA, MN 55303			
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S	PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		CROSS-REFERE	CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 880	Continued From page	• 51	F	880				
	LACK OF WATER MA	ANAGEMENT PROGRAM						
	FOR FOR LEGIONEL							
		p.m., the director of nursing						
	(DON) stated she was control program, espe	s in charge of the infection						
		ing of resident infections in						
		knew the facility "had a						
	policy" regarding prev							
	-	she was not aware of the						
	water management as							
		ity's monitoring of the water potential start or spread of						
		stated the facility had no						
	-	ated pneumonia infections.						
	A facility policy, Legio	nella Water Management						
	0 .	dicated Legionella infections						
	can cause a serious t							
		e) in persons at risk, and						
	that outbreaks have b	tem in building with large or						
		ns, including hospitals and						
		es. The policy indicated the						
	Water Management P	Program included key						
	elements:							
	- conducting a rick as	sessment to identify where						
	-	opportunistic waterborne						
	pathogens could grow							
	- implementing a wate	er management program						
	•	sures, inspections and						
	environmental testing							
	<ul> <li>testing protocols, ac measures, documenta</li> </ul>	ceptable ranges of control						
		en when control limits are						
	not maintained.							
	A Center for Disease	Control (CDC) document,						

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		ND HUMAN SERVICES				RM APPROVE 10. 0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION		TE SURVEY MPLETED	
		245298	B. WING		1	2/01/2017	
NAME OF PI	ROVIDER OR SUPPLIER	•	:	STREET ADDRESS, CITY, STATE, ZIP C			
	TES AT TWIN RIVERS L	10	;	305 FREMONT STREET			
				ANOKA, MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE	
F 880	Continued From page	e 52	F 880				
		Vanagement Program to	1 000				
		browth & Spread in Buildings,					
		ed Legionnaire's disease was					
		umonia caused by bacteria,					
	-	t live in water. Legionella					
	can make people sicl	-					
	that are not adequate	rom building water systems					
		r management program can					
		sk for growing and spreading					
	Legionella.						
	When interviewed on 12/1/17, at 11:07 a.m., the facility administrator stated the facility "did not have" a formal water management program in response to Legionella. The administrator stated there was a corporate policy in place, and the facility did the first part of the CDC "toolkit" assessment, which determined the need for a water management plan, and there were also some bath cleaning policies. The administrator stated the facility had not completed a full assessment, or analyzed the building's water supply and tubs, or had a monitoring plan. The administrator stated we need a program and "we are working toward it."						
	Program, dated 8/17, of infection preventio established general a guidelines such as th Disease Control (CD	and disease-specific lose of the Centers for C).					
F 912 SS=B	Bedrooms Measure a CFR(s): 483.90(e)(1)	at Least 80 Sq Ft/Resident (ii)	F 912	2		1/10/18	
		asure at least 80 square feet le resident bedrooms, and at					

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	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED			
		245298	B. WING					
	ROVIDER OR SUPPLIER	245250		STREET ADDRESS, CITY, STATE, ZIP CODE	12/01/2017			
	NOVIDER OR GOIT EIER			305 FREMONT STREET				
THE ESTA	TES AT TWIN RIVERS LI	LC		ANOKA, MN 55303				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETIC			
F 912	least 100 square feet This REQUIREMENT by: Based on observation review, the facility fail of floor space per resi rooms (room#s 4, 7, 1) which affected 13 res R9, R141, R25, R26, currently resided in th The following double the required minimum resident: Room 4 = 150 square resident, (R38) Room 7 = 152.5 squa per resident, (R240 at Room 17 = 150 squar resident, (R10) Room 20 = 150 squar resident, (R25 and R2 Room 29 = 150 squar resident, (R2 and R4)	in single resident rooms; is not met as evidenced n, interview and document ed to provide 80 square feet ident in 8 of 28 resident 17, 20, 21, 29, 35 and 36) idents (R38, R240, R8, R10, R2, R4, R3, R90, R23) who ese rooms. resident rooms did not meet a square footage per e feet, or 75 square feet per re feet, or 75 square feet per the feet, or 75 square feet per e feet, or 75 square feet per the feet, or 75 square feet per	F 912		rding be 7, 20, 21, 1962 rements dent ble to hout versely ealth, ellbeing possible eerns or ize.			
	resident, (R3)	e feet, or 77.5 square feet						

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391	
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED	
		245298	B. WING			12	/01/2017	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		•	
THE ESTA	TES AT TWIN RIVERS L	LC			05 FREMONT STREET ANOKA, MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 912	Continued From page	e 54	F	912				
		peing used as a private the potential to occupy two is identified.						
	stated she did not ha and she was very cla	1/30/17, at 12:19 a.m. R240, ve enough room in her room ustrophobic, but was al worker to be transferred to						
	who resided in Room	2/1/17, at 11:48 a.m. R8, 7 stated she had enough e needed in her room.						
	stated she had no iss	1/28/17 at 4:15 p.m. R10 ues. She wished it could be facility has offered her a e likes this room.						
	stated he just got bac he was admitted on T	01/17 12:58 p.m. R141 k for the hospital from when uesday and had no issue 9 who was in the room was preference.						
	-	n 12/01/17 12:58 p.m. R25 cerns about the room size. , and not available.						
		dated 8/18/17 indicated he vities of daily living (ADLs) ognition.						

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 01/31/2018 MAPPROVED D. 0938-0391	
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		245298	B. WING			_	12/	01/2017	
NAME OF PI	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, S	TATE, ZIP CODE	•		
	ATES AT TWIN RIVERS LI			3	305 FREMONT STREET				
				A	ANOKA, MN 55303				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BI ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 912	Continued From page	÷ 55	F	912					
		dated 8/18/17 indicated he ADLs and was moderately,							
	room #29 was set up a hanging curtain divi- of the room door was was a TV. Next to the positioned lengthwise R4 was in the room, s watching TV. On the curtain was a recliner against the wall, at the Immediately next to th bed, positioned length R2, seated in the recl watching his TV, whic located about 6 feet in	ne recliner was the second nwise next to the window. iner, was dozing off, ch was on top a small stand							
	who lived in room #29 facility for "some time need." R-2 stated the you just had to keep t staff were good about clear" and added his n During interview on 1° assistant (NA)-D state smaller rooms, "its sm	<ul> <li>a), stated he had been in the</li> <li>a), stated he had been in the</li> <li>and "I can get the care I</li> <li>b) room space was tight, and</li> <li>c) the space clean. R2 stated</li> <li clean.="" li="" r2="" space="" stated<="" the=""> <li< td=""><td></td><td></td><td></td><td></td><td></td><td></td></li<></li></li></li></li></li></li></li></li></ul>							
	years, and you just ha first. NA-D stated tha small, there was "noth the residents.	ave to move things around at although the rooms were hing" we can't get done for 11/29/17 at 2:15 p.m. NA-E							

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/31/2018 MAPPROVED D. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245298	B. WING			12/	01/2017	
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
THE ESTA	TES AT TWIN RIVERS LI	LC		-	305 FREMONT STREET ANOKA, MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 912	stated when providing you had to do "some" hand, and within reac cares. NA-E stated d learning to manage th that it required "a lot of not being able to prov rooms, like room #29. When interviewed on who lived in room 29 small." R4 questione was needed, and stat a little more room. R4 in getting cares done, concern" as to the root During interview on 11 stated although she w tiny room, resident root the main walkway into providing cares to res curtains. LPN-E state "a little inconvenient," them done. Room 35: During observation or room 35 had two sing stands. There were r resident equipment in R3 quarterly MDS dat had moderate cognitiv extensive staff assista interview on 11/28/17 bed, and stated she for	g cares in the small room, organizing" and have on th, what you need to do the long the cares was about ne space you have, and also of patience." NA-E denied vide cares in the smaller 11/29/17 at 2:30 p.m. R4, stated the room was "kinda d how much more space ted "It would be nice" to have 4 denied having any difficulty and stated he had "no om size. 2/1/17 at 8:10 a.m., LPN-E vould not want to live in a oms were organized to keep to the room "clear," and when sidents, you use the privacy ed doing cares maybe was but staff worked to get	F	912				

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 01/31/2018 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		(X3) DATE	
		245298	B. WING			_	12/	01/2017
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, S	TATE, ZIP CODE		
THE ESTA	TES AT TWIN RIVERS LI	LC			305 FREMONT STREET ANOKA, MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 912	Continued From page in room 35.	9 57	F	912				
	11:23 a.m. there were bedside stands and o no other care equipm R23's quarterly MDS R23 had intact cogniti ADL's, needed staff a and independent with interview on 11/28/17 she doesn't need any discharge soon. She room size and was ab independently without R90 was interviewed and stated she was ju few days ago and use She stated she was a without any problems small, but she did not the size.	ane wheelchair. There was ent identified in the room. dated, 10/24/17, identified ion, was independent with assistance with set up only a ambulation. During at 11:23 a.m. R23 stated r staff help and plans to had no concerns with her ole to maneuver t any concerns. on 11/28/17 at 10:00 a.m. ust admitted to the facility a es a wheelchair in her room. able to maneuver in her room. The size of the room was t have any concerns about 1/30/17 at 8:56 a.m. NA-F						
	stated she had no pro equipment or resident keep residents whom these rooms. The roo been there for so mar move equipment and rooms.	bblems with maneuvering ts in room 35 or 36. They are more independent in oms are small but she had ny years she knows how to residents around in these 12/1/17 at 8:44 a.m., the						
	director of nursing (D							

Facility ID: 00866

If continuation sheet Page 58 of 64

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		245298	B. WING			12/	01/2017
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE ESTA	TES AT TWIN RIVERS LI	LC			05 FREMONT STREET NOKA, MN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 912 F 921 SS=F	rooms, and stated the year. The DON state residents are offered rooms, then asked if t if the resident will be DON stated residents when assigning to av stated if a resident re- bariatric bed, or a larg example, they would small room. The DOI happy with the smalle would offer" to re-arra resident preference o the resident a different the smaller rooms did to complete resident of that if there were con- future, the facility wou needed. The facility's request the following health d forwarded to the CMS determination. F-912 42 CFR 483. MEASURE AT LAST Approval of the waive recommended. Safe/Functional/Sanit CFR(s): 483.90(i)	e room size comes up every ed prior to admission, a tour and are shown the they would like it, especially staying long-term. The ' needs were considered ailable rooms. The DON quired a mechanical lift, a ge oxygen canister, for avoid placing him or her in a N stated if resident was not er room, or any room, "we ange the current room to the r, following protocol, offer at room. The DON stated I not mean staff were unable cares. The DON also stated cerns about room size in the ild address those issues as for a continuing waiver of eficiency(ies) has been S Region V Office for its 70(d)(1)(ii) BEDROOMS 80 SQ FT/RESIDENT. er request has been cary/Comfortable Environ		912			1/10/18
	§483.90(i) Other Envi The facility must prov sanitary, and comfort residents, staff and th	ide a safe, functional, able environment for					

Facility ID: 00866

If continuation sheet Page 59 of 64

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/31/2018 FORM APPROVED OMB NO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245298	B. WING		12/01/2017
NAME OF PI	ROVIDER OR SUPPLIER	·	•	STREET ADDRESS, CITY, STATE, ZIP CODE	·
	TES AT TWIN RIVERS L			305 FREMONT STREET	
THE ESTA	TES AT TWIN RIVERS L			ANOKA, MN 55303	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION
F 921	by: Based on observatio review, the facility fail was kept clean, sanit	is not met as evidenced in, interview and document led to ensure the kitchen ary and in good repair which ffect all 43 residents who	F 92	The areas of concern identified we addressed by culinary services and maintenance staff. The entire kitch been thoroughly cleaned to provide clean and sanitary environment. Th process has been initiated regardir repair to the flooring and walls in th kitchen.	d en has e a ne ng
	9:15 a.m. with the Cu (CSM), a certified die facility registered diet fed 43 residents from items were noted: A kitchen garbage ca washing sink had a a	f the kitchen on 11/28/17, at linary Services Manager stary manager, and the sitian (RD)-A identified they the kitchen, the following n located near the hand lid, that was covered in dirt, a dried gray substances		Culinary services staff have been re-educated on facility polices and procedures for cleanliness of the ki and equipment. Audits will be completed weekly x 4 and then as needed to ensure kitch cleanliness.	4 weeks
	splashed on the lid. dirt, dust, debris that the garbage can. Near the hand washin metal cart that had a Decker blender along appliances on the car dust, crumbs and drie of the metal cart were dust and debris. Through out the kitch accumulation of vario a sticky residue that s in front of the refriger approximately four fe	The external can also had was dried on the outside of ng sink was a four wheeled base of an Oster Black and g with other kitchen rt that were covered with ed debris. The three shelves e also covered with crumb, when, the floor had an bus debris, dirt, crumbs and stuck your shoes to the floor ator. The area was et in diameter. Under the boves, cook and prep area		The Culinary Service Manager or designee will be responsible. QAPI committee will review results provide redirection or change wher necessary and dictate continuation completion of this monitoring proce based on compliance date.	ו or

If continuation sheet Page 60 of 64

PRINTED: 01/31/2018

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE	
		245298	B. WING			12/	01/2017
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE ESTA	ATES AT TWIN RIVERS LI	LC			305 FREMONT STREET ANOKA, MN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 921	There was a visible h debris that was black wheels and legs of th refrigerator. There was a stainless near the prep station splashed on the sides cart, along with dirt, c shelves of the cart. C transporting food item There was baseboard of the dry storage are approximately 8 inche exposed the dry wall There was a plastic th storage area, that wa debris on each of the this was used for tran- items in the kitchen o The dishwasher had a residue on the outside up of this white subst supports of the dishw The facility produce re crumbs and food deb the refrigerator. The chest freezer had bottom of the freezer, The refrigerator/freez room, had shelves wi	is under all of these areas. eavy build up of dirt and in color located under the e portable prep station, and a steel three shelf chart, with dried food, and debris a and lateral supports of the rumbs and debris on the SM stated they used this for as in and out of the kitchen. It missing near the entryway a. The area was es long by 4 inches long, and behind the baseboard. hree shelf cart in the dry s full of dust, crumbs and se shelves. CSM identified sporting food, and other r to residents in the facility. a heavy white, cloudy e. There was a heavier build ance on the four corner asher.	F	921			

Facility ID: 00866

If continuation sheet Page 61 of 64

PRINTED: 01/31/2018

		ID HUMAN SERVICES MEDICAID SERVICES					FORM	APPROVED
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·				(X3) DATE	SURVEY
		245298	B. WING			_	12/	01/2017
NAME OF PI	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
THE ESTA	TES AT TWIN RIVERS LI	LC						
			STREET ADDRESS, CITY, STATE, ZIP CODE 305 FREMONT STREET ANOKA, MN 55303 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE DEFICIENCY) F 921 F 921 S S S S S S S S S S S S S					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX		(EACH CORREC CROSS-REFEREN	CTIVE ACTION SHOULD B		COMPLETION
F 921	Continued From page	e 61	F 92	21				
	had a heavy build of various creamy color sticky							
		he shelves. There were						
		e cream cups in the freezer.						
	-	erator/freezer door there was debris on the bottom and						
	· ·	tor and freezer door, along						
	0 0	nce under the handles of the						
	refrigerator and freezo	er.						
	During kitchen tour or following items were i	n 11/30/17, at 9:25 a.m. the identified:						
	had visible dirt, debris	e three compartment sink s and cob webs. The sink						
	-	ild up across the top of the faucets and faucet handles.						
		e units where pots, pans,						
	lids and plastic contai	ebris. The sliding door tracks						
		nd a brown substance in the						
		icult to close the cupboard						
	-	vere three plastic bins, that						
	-	on the sides, and under the rown debris. Inside the two						
		is dried food, and crumbs on						
	-	s a heavy build up of brown						
		edges of the oven doors						
	that could be scraped	l off with a fingernail.						
	The dish room had 12	2, 12x12 floor tiles in the						
	-	d under the dishwasher. The						
	tile corners were brok							
		type cracks that extended						
	-	of the 12x12 tiles. Other tiles						
	-	ugh the entire width of the asher was a heavy build up						
		or debris. Under the clean						
	-	xt to the wall had an area						

Facility ID: 00866

If continuation sheet Page 62 of 64

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	SURVEY
		245298	B. WING			12	/01/2017
NAME OF P	ROVIDER OR SUPPLIER	L	<b>I</b>	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE ESTA	TES AT TWIN RIVERS L	LC		305 FREMONT STREET ANOKA, MN 55303		ILD BE COMPLETION	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	COMPLETION
F 921	colored substance. The build up of a white vise between the dish room 4x4 inch white tiles main linoleum piece in this baseboard and wall m Behind the linoleum w Across the wall in the splattered with a tan, approximately 8 feet hagainst this wall were Review of the daily cli- thirteen plus areas for wipe off all carts, clear stoves, ovens, wipe of The bottom of the form complete daily cleanin action." Review of the facility from October 30 to Ne 81 of 112 shifts clean During interview on 1 and CSM both stated needed some more w have been busy with also been working in just need more oversi- changes. Review of the Monard undated, identified ear in a clean, sanitary co Director is responsible cleaning scheduled in	by 2 foot long of a slimy tan he dish racks had a heavy sible substance. The wall m and kitchen area had 4, issing. There was a area between the tot attached to the wall. vas a hole in the wall. dish area the tiles were brown substance long and 4 feet high. Lying five clean dish racks. eaning schedules identified r daily cleaning of the floors, an and wipe off all shelves, lown and clean coffee area. m identified, "Failure to ng may result in disciplinary shift cleaning schedules ovember 26, 2017 identified	F	921			

Facility ID: 00866

If continuation sheet Page 63 of 64

PRINTED: 01/31/2018

		ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 01/31/2018 MAPPROVED ). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		245298	B. WING				12/	01/2017
NAME OF P	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STAT	TE, ZIP CODE		
THE ESTA	ATES AT TWIN RIVERS L	LC			5 FREMONT STREET IOKA, MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S F (EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA FFICIENCY)		(X5) COMPLETION DATE
F 921	duty, and to carry it o Each employee is res specified area for the	ut during their work shift. sponsible to document in the	F	921				

Event ID: 23SE11

Facility ID: 00866

If continuation sheet Page 64 of 64

		AND HUMAN SERV & MEDICAID SERV		1	5298027	FORM	12/13/2017 APPROVED 0938-0391
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		1 · · ·	DE CONSTRUCTION	(X3) DATE SU COMPLE	
		245298		B. WING		11/29	9/2017
	ROVIDER OR SUPPLIER				TATE, ZIP CODE		
THE EST	TATES AT TWIN RIV	ERS LLC		EMONT ST ., MN 5530			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE T BE PRECEDED BY FULL INTIFYING INFORMATION	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	rs		K 000			
	FIRE SAFETY						
4 12	An annual Life Safe conducted by the M Public Safety, State November 29, 2017 The Estates at Twin compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National I (NFPA) Standard 1 Chapter 19 Existing edition of NFPA 99, Code.	ety Code survey was finnesota Departmer e Fire Marshal Divisio 7. At the time of this n Rivers was found in e requirements for pa aid at 42 CFR, Subpa ety from Fire, and the Fire Protection Assoc 01, Life Safety Code g Health Care and the the Health Care Fac	nt of survey, n articipation art 2012 ciation (LSC), e 2012 cilities		i. T	2	
	with a partial baser addition in 1977 an Type II(111) constru- protected througho sprinkler system ar smoke detection in open to the corrido automatic fire depa	apacity of 56 beds a	2 with an be of fully re ystem with baces for	12			
	The requirement at MET.	t 42 CFR, Subpart 48	33.70(a) is				19
			-				
			22		2 2	U.	
		11			-		
LABORATO	RY DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRES	ENTATIVE'S SIG	NATURE	TITLE		(X6) DATE

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.



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 18, 2017

Ms. Becky Willett, Administrator The Estates at Twin Rivers LLC 305 Fremont Street Anoka, MN 55303

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5298029

Dear Ms. Willett:

The above facility was surveyed on November 28, 2017 through December 1, 2017 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 <u>only a suggestion</u> 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 <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. 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.

An equal opportunity employer.

The Estates at Twin Rivers LLC December 18, 2017 Page 2

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 Unit Supervisor Brenda Fischer at brenda.fischer@state.mn.us or (320) 223-7338.

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 related to this electronic notice.

Sincerely,

Anne Retenson

Licensing and Certification Program Minnesota Department of Health P.O. Box 64900 St. Paul, MN 55164-0900 anne.peterson@state.mn.us Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

Minnesot	a Department of Healtl	1				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	CONSTRUCTION	(X3) DATE S COMPL	
AND FLAN (	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:		COWFL	ETED
		00866	B. WING		12/0	)1/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
THE ESTA	TES AT TWIN RIVERS L		ONT STREET			
		ANOKA, N	IN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTEN	TION*****				
	NH LICENSING C	ORRECTION ORDER				
	144A.10, this correcti pursuant to a survey. found that the deficient herein are not correct not corrected shall be with a schedule of fin- the Minnesota Depart Determination of whe corrected requires co- requirements of the re- number and MN Rule When a rule contains comply with any of the lack of compliance. Live- re-inspection with any result in the assessmit	ther a violation has been				
	that may result from r orders provided that a	earing on any assessments non-compliance with these a written request is made to n 15 days of receipt of a for non-compliance.				
	receipt of State licens the Minnesota Depart Informational Bulletin	articipate in the electronic sure orders consistent with ment of Health 14-01, available at te.mn.us/divs/fpc/profinfo/inf icensing orders are				
ABORATORY	partment of Health DIRECTOR'S OR PROVIDER/S cally Signed	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE 12/27/17

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00866	B. WING		12	2/01/2017
IAME OF PF	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
HE ESTA	TES AT TWIN RIVERS L	LC	MONT STREET MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 000	Continued From pag	e 1	2 000			
	you electronically. A is necessary for State enter the word "correc- text. You must then in State licensure proce- completion date, the corrected prior to ele Minnesota Department On 11/28/17 through Department's staff, w the following correcti Please indicate in you correction that you ha and identify the date Minnesota Department the State Licensing Of federal software. Tag assigned to Minneso Nursing Homes. The appears in the far lef Tag." The state statut listed in the "Summa column and replacess the correction order. the findings which ar statute after the state as evidence by." Foll are the Suggested M Time period for Correct PLEASE DISREGAR FOURTH COLUMIN "PROVIDER'S PLAN APPLIES TO FEDER	12/1/17, surveyors of this risited the above provider and on orders are issued. For electronic plan of ave reviewed these orders, when they will be completed. The top the the top the top top top correction Orders using on umbers have been tha state statutes/rules for assigned tag number the column entitled "ID Prefix ute/rule out of compliance is ry Statement of Deficiencies" the "To Comply" portion of This column also includes the in violation of the state ement, "This Rule is not met lowing the surveyors findings lethod of Correction and ection. RD THE HEADING OF THE WHICH STATES, NOF CORRECTION." THIS RAL DEFICIENCIES ONLY.				
	THIS WILL APPEAR					
	THERE IS NO REQU	JIREMENT TO SUBMIT A				

	a Department of Health OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00866	B. WING		12/01/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ITE, ZIP CODE	
HE ESTA	TES AT TWIN RIVERS LI	_C	MONT STREET		
			MN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLET
2 000	Continued From page	2	2 000		
	PLAN OF CORRECT MINNESOTA STATE	ION FOR VIOLATIONS OF STATUTES/RULES.			
2 560	MN Rule 4658.0405 S Plan of Care; Content	Subp. 2 Comprehensive s	2 560		1/10/18
	objectives and timetal long- and short-term of and mental and psych identified in the comp assessment. The cor must include the indiv required by Minnesota subdivision 14, parag This MN Requirement by: Based on interview and faciltiy failed to ensure were developed for ra- splints and activities for who were dependent	of care must list measurable bles to meet the resident's goals for medical, nursing, nosocial needs that are rehensive resident mprehensive plan of care ridual abuse prevention plan a Statutes, section 626.557, raph (b). t is not met as evidenced and document review the e comprehensive care plans inge of motion (ROM), or 1 of 7 residents (R15) upon staff for activities of		corrected	
	daily living and rehabi Findings include:	litation.			
	no upper or lower ext	0/2/17, identified R15 had remity impairments, no was not involved in a program.			
	9/26/16 identified R15 (paralysis right side of of his right fingers, no	upational Therapy (OT) note, 5 had right hemiparesis f body) with trace movement active range of motion in nd PROM within functional			

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
			A. BUILDING.			
		00866	B. WING		12	2/01/2017
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
THE ESTA	TES AT TWIN RIVERS L		MONT STREET MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 560	Continued From page 3		2 560			
	limited with verbaliza flexion past 140 degr	tion of pain when should ees.				
		or nursing to apply right hand of sleep and remove with				
	form, dated, 12/1/2 maintenance progr	Therapy Communication I6, identified functional n (FMP) provide ROM to twice a day, five repetitions nd wrist.				
	right upper extremity	rapy (OT) discharge lentified nursing to continue ROM, and right hand at night and off during the				
	9/25/17 identified bila passive range of mot limits. Limited range of hemiparesis/brain inju on functional mainter	upational therapy note, ateral upper extremity ion (PROM) within functional of motion related to ury. Nursing reports (R15) nance program (FMP) for previous therapy in nursing				
		note 10/3/17 identified a d to continue the program, ed or declined.				
	problem with physica mobility impairment, l	t date 12/1/17, identified a I functioning related to but did not address the use or any restorative nursing e care plan.				
	Review of the facility	treatment administration				

STATEMENT	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00866	B. WING		1:	2/01/2017
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
THE ESTA	TES AT TWIN RIVERS L	LC	MONT STREET			
_		ANOKA	, MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
2 560	Continued From pag	e 4	2 560			
	November 2017, did	eptember 2017 through not identify any range of splint identified as part of the				
	sheets, a form used identified under R15' splint on when in bec	Team #4, nursing assistant by nursing assistants 's ADL's were "Right hand d, off in AM [morning]." There ny nursing rehabilitative et.				
	Physical Therapy (D functional maintenan 3/16/17 and the last identified he was still to right hand. There FMP or splinting pros	12/01/17 12:13 p.m. Director PT) stated R15 was on a lice program with PROM on therapy note on 10/3/17 I on that program and a splint was no mention that R15 gram had been stopped and eiving this as identified in the				
	nursing (DON) stated right hand splint, but FMP PROM program care plan did not ide	2/01/17 12:35 p.m. director of d she was aware (R15) had a did not know (R15) had a n. The DON reported R15's ntify the right hand splint or gram which should be ne care plan.				
	10/2/17 identified R1 needed extensive to activities of daily livir were identified by the identified R15's prefe newspaper, music, a					

Minnesota Department of Health STATE FORM

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STATEMENT	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00866	B. WING		12	2/01/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE, 2	ZIP CODE	•	
THE ESTA	TES AT TWIN RIVERS L	LC	MONT STREET MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 560	very important. Review of the facility Review, dated 10/2/1 attendance and partii resident has joined g such as meals in the current events. Resid activities such as war Resident does attend which limits participal activities as identified family and independe watching sports. Resimilitary veteran. and identified the plans re- per care plan, goal w were effective in read Review of R15 care p not have any information participation or interview meet R15's activity n During interview on 1 Therapeutic recreation do a quarterly review before his care confe evaluation under sec monthly basis we tra- unsure of what R15's this was measured o Although R15 was de unable to physically p without staff assistant	Igious services were all not MHM Activity Participation 7 identified under the cipation summary. The roup activities infrequently dining room, snack cart and dent enjoys impendent tching TV and sports. I dialysis three times a week tion. Resident's favorite d as he prefers visits form ent activities. Resident enjoys ident if proud of being a the activity plan review emain appropriate/current as rere met and interventions ching goal. Dan print date, 12/1/17, did tion about activity goals, rentions implemented to eeds. 12/01/17 11:41 a.m. on director (TRD) stated they of his activity participation erence, and then an annual tion F of the MDS. On a ck his participation. She was a activity goals were or how	2 560	DEFICIENCY		

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00866	B. WING		12/01/2017	
AME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
HE ESTA	TES AT TWIN RIVERS LI	C	MONT STREET			
			MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
2 560	Continued From page	96	2 560			
	director of nursing or and/or revise policies the development of th appropriate care is pr	OD OF CORRECTION: The designee could review and procedures related to the care plans to ensure ovided. Education could be and a system to monitor for developed.				
	TIME PERIOD OF CO (21) days.	DRRECTION: Twenty-one				
2 565	MN Rule 4658.0405 S Plan of Care; Use	Subp. 3 Comprehensive	2 565			1/10/18
		prehensive plan of care ersonnel involved in the				
	by: Based on observatior review, the facility fail for activities, oral care 3 of 5 residents (R39,	t is not met as evidenced a, interview and document ed to follow the plan of care e and shaving facial hair for R15 and R1) reviewed who a staff for assistance with g (ADLs).		corrected		
	Findings include:					
		num Data Set dated 8/17/17, speech and was rarely noderately severe				

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
			B. WING			
		00866			12	2/01/2017
AME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
HE ESTA	TES AT TWIN RIVERS L	LC	, MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pag	e 7	2 565			
	altered socialization of communicate. Goals continue daily independent and participate in sho Interventions include stimulating music, ter During observations 2:28 p.m. R1 was lyin without any music, ter staff aside from required turning and reposition During interview on a member (FM)-A state visited, on almost a construction buring observations 6:20 p.m. R1 was lyin without any music, ter staff aside from required turning and reposition During interview on a sistant (NA)-J state lying in bed and didin on for any stimulation During observations through 12:37 p.m. w were on without any interaction from staff	for R1 included R1 would endent activities in his room ort one on one weekly visits. d providing R1 with with levision and other activities. on 11/28/17, at 9:00 a.m. to ng in bed with the lights on elevision or interaction from ired care (medications, ning) from staff. 11/28/17, at 2:30 p.m. family ed R1 when the family daily basis) R1 was always any music or television. on 11/29/17, at 1:00 p.m. to ng in bed. The lights were on elevision or interaction from ired care (medications, ning) from staff. 11/29/17, at 7:43 p.m. nursing ed R1 spent most of his time 't have music or a television n. on 11/30/17, at 6:54 a.m. vas lying in bed. The lights				
	During interview on 1	12/1/17, at 10:27 a.m. DON) stated R1's current				

TATEMENT OF DEI ND PLAN OF CORI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
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AME OF PROVIDE		00866	ADDRESS, CITY, STATE		12	/01/2017
		305 FRE		, 0002		
HEESIAIESA	T TWIN RIVERS L	ANOKA	, MN 55303			
PREFIX (EACH DEFICIENCY MUST BE		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565 Cont	inued From pag	e 8	2 565			
care	plan should be	followed.				
R395 Minir 9/27/ defic (strol R39 comp had i 7/12/ defic Durir a.m., to tal suga R39 the lo pract re-ch nursi morm towe routin place lift, a trans NA-E aske to wh	num Data Set (I 17, included ca it following cere (e) and left hem required extens blete ADLs. The ntact cognition. 17, identified R3 it, but was able or observation ca licensed practic (a his blood sug r, LPN briefly ex- with some milk ower blood sug ical nurse (LPN leck a blood sug ing assistant (N/ ing cares. NA- ls and clothing a base. NA-B washe ca a lift sling und nd with assistant ferred R39 from g groomed R39	identified on the annual MDS) assessment dated ognitive, social or emotional bral vascular disease iplegia, and also indicated ive assistance of staff to e MDS also indicated R39 R39's care plan, revised 39 had a physical functioning to brush teeth after set up. on 11/30/17 beginning at 6:51 cal nurse entered R39's room gar. After getting the blood kited the room and provided and jelly to eat in response to ar. At 8:22 a.m., licensed )-A entered R39's room to gar, and left the room when A)-B greeted R39 to begin B gathered care supplies, and began R39's morning ed and dressed R39, then der R39. Using a mechanical nee of NA-E, NA-B n the bed into the wheelchair. s face, combed his hair, and ras anything else he needed, bis bead. During this				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		00966	B. WING				
	ROVIDER OR SUPPLIER	00866	B. WING 12/01/20				
		305 FRE		,211 000E			
THE ESTA	ATES AT TWIN RIVERS L	LC ANOKA,	MN 55303				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 565	Continued From page	e 9	2 565				
	R39 back to his room wanting to remain in TV. NA-B adjusted th R39's likings, placed chair and exited R39' provision nor offer to following breakfast. I until after he was ass his room at 12:08 p.m When interviewed on NA-b stated she had this morning and mis I just forgot to offer to that (R39) was deper his oral cares. During interview on 1 stated the care plans should be offered and teeth. LPN-A stated	11/30/17 at 12:30 p.m., lots of residents to assist sed to offer R39 oral cares. " both brushing." She stated indent upon staff to complete 11/30/17 at 1:02 p.m., LPN-A should be followed and R39 d assisted as need to do his staff need to try, and try eded, and added R39's teeth					
	When interviewed on director of nursing (D should be at least off evening to all residen expected oral cares r residents, not forced, re-approach or have DON stated staff wer twice daily." SHAVING R15's annual Minimu 10/2/17 identified R12 needed extensive to	12/1/17 at 8:49 a.m., the ON) stated oral cares ered in the morning and hts. The DON stated she needed to be offered to					

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TATEMENT	a Department of Heal	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
			B. WING			
		00866		7/0.0005	12	2/01/2017
	ROVIDER OR SUPPLIER	305 FREI	DDRESS, CITY, STATE MONT STREET	, ZIP CODE		
HE ESTA	TES AT TWIN RIVERS I	LLC ANOKA,	MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From page 10		2 565			
	cares.					
	was physical function care impairment and	t date 12/1/17 identified R15 ning deficit related to self I ability with ADL's can vary. o provide personal hygiene				
	bed watching televis communicate and ha 11/29/17 5:56 p.m. F unshaven with visible 6:49 a.m. R15 was in for the day. He was facial hair approxima p.m. R15 was in bed visible facial hair and past few days. On 12 continued to be unst	on 11/28/17 10:08 a.m. in his ion, he was unable to ad visible facial hair. On R15 was at nursing station e facial hair. On 11/30/17 at n his wheelchair and dressed unshaven and had visible ately 1/8 inch long. At 12:30 I watching television with d had not been shaven for the 2/01/17 at 8:58 a.m. R15 naven with visible facial hair at approximately 10:00 a.m.				
	practical nurse (LPN responsible for (R15 assistants (NA's) are whenever he has "lo NA-H who was R15" shaves (R15) when shave him today but They do not shave h needed because he shave him. During th care of him on Thurs	12/01/17 11:08 a.m. licensed )-E stated they were 's) shaving and the nursing e suppose to do this, ts of beard." At 11:10 a.m. s NA for the day stated she he is "scruffy." I was going to dialysis come and got him. im every day, only when it is pulls away when we try to his time NA-G stated she took aday (11/30/17) and she did use he doesn't like his face				
		Point Of Care form identified assistance with personal				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00866	B. WING		12	2/01/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	•	
THE ESTA	TES AT TWIN RIVERS L	LC	MONT STREET MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 565	hygiene that included documentation from check marks in place shifts which identified completed for R15. In an interview on 12 nursing (DON) stated click care documenta residents. SUGGESTED METH director of nursing or review/revise policies the implementation of	d shaving. Review of the 11/18/17 to 12/1/17 had e for both days and evening d personal hygiene was //01/17 12:35 p.m. director of d staff are to follow the point ation when providing cares to	2 565			
2 570	compliance could be TIME PERIOD OF C (21) days. MN Rule 4658.0405 Plan of Care; Revisio	ORRECTION: Twenty-one Subp. 4 Comprehensive	2 570			1/10/18
	care must be reviewed interdisciplinary team physician, a registere for the resident, and disciplines as determ and, to the extent pr participation of the re- guardian or chosen r quarterly and within s	ed and revised by an that includes the attending ed nurse with responsibility other appropriate staff in nined by the resident's needs, acticable, with the esident, the resident's legal epresentative at least seven days of the revision of esident assessment required				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00866	B. WING		12	12/01/2017	
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STA	ITE, ZIP CODE			
THE ESTA	TES AT TWIN RIVERS L	LC	MONT STREET				
			, MN 55303				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 570	Continued From pag	e 12	2 570				
	This MN Requiremer by:	nt is not met as evidenced					
	Based on observation review, the facility fait plans with updated in residents (R1, R25) n 3 (R15) residents rev	n, interview and document led to revise resident care nterventions for 2 of 3 reviewed for accidents, 1 of viewed for pressure ulcers, 1 reviewed for incontinence, (R26) reviewed for		corrected			
	Findings include:						
	persisting dementia a nicotine dependence anemia identified on sheet. The annual m dated 10/20/17, indic intact and require lim of daily living (ADLs) Assessment (CAA) for needed assistance w	or ADLs indicated R25 vith ADLs, this resident did d, and the assistant level					
	smoking on 11/29/17 noticed not to have a	eturning back inside after at 6:27 p.m R25 was iny clothing or shin burns. supervised nor adaptive smoking apron.					
	practical nurse (LPN were stored in the m observing R25 smok	, R25 asked licensed )-A for two cigarettes, which edication cart. While e, resident did not display behaviors. LPN-A stated the					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
			A. BUILDING.			
		00866	B. WING		12	2/01/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
THE ESTA	TES AT TWIN RIVERS L	LC	MONT STREET MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 570	Continued From page	e 13	2 570			
	cart and has 3 times a day he smokes wh is given 2 cigarettes each time. LPN-A sta (R25) was independent with smoking and wear a smoking apron.					
	10/24/17, the facility independent with sm issues once or twice accidentally dropping concerns at present.' assessments, dated supervisor, and the a indicted R25 needed	ing Evaluation, last assessed indicated: "Resident is oking. Resident has had a in the past 3-4 months of g his cigarette, however no " In further review of previous 8/24/17, R25 needed assessment dated 3/23/17, a smoking apron. There he use of a smoking apron				
	11/03/15), indicted: "/ injury related to: Smo Goal indicated: "I will injuries." The interve facility would "obser smoking behaviors o material from outside	e plan (initiation date of At risk for smoking related okes with supervision. The have no smoking related entions included: that the ve patient for unsafe r attempts to obtain smoking e sources" and that the e smoking apron while				
	director or nursing (D "supervising R25 with are not outside, while cigarettes." The DON	on 11/30/17 at 12:10 p.m., the DON) stated the facility is still h his smoking, even if they e they are holding on to his N stated the smoking apron due to resident refusals.				
	indicated R1 had no understood and had	num Data Set dated 8/17/17, speech and was rarely moderately severe S indicated R1 needed total				

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	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		00866	B. WING		12/01/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE	•	
THE ESTA	TES AT TWIN RIVERS L		MONT STREET			
_		ANOKA	, MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
2 570	Continued From page	e 14	2 570			
	with locomotion on th aphasia (loss of abilit speech, caused by b	r and extensive assistance he unit. Diagnoses included ty to understand or express rain damage) stroke and der. The MDS indicated R1 without injury since				
	R1's care plan dated 11/10/17, indicated R1 was at risk for falls and indicated a concave mattress was in place.					
		n 11/29/17, at 6:00 p.m. R1 ic sized bed without a				
	stated R1 used to hat his mattress was rep	1/29/17, at 7:43 p.m. NA-J ve a concave mattress but laced with a larger bed. NA-J le mattress was replaced.				
	stated R1's concave a bariatric bed as R1 thought that would he	2/1/17, at 10:27 a.m. DON mattress was replaced with moves a lot in bed, and elp prevent falls. DON stated e been revised to reflect				
		hen the mattress was ted and was not received.				
	10/2/17 identified R1 needed extensive to activities of daily livin ulcer (PU) developme PU (Partial thickness a shallow open ulcer	S m Data Set (MDS) dated, 5 had severe cognition, total assistance for all g, was at risk for pressure ent, and a current stage 2 loss of dermis presenting as with a red-pink wound bed). ent of pressure reductions				

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If continuation sheet 15 of 52

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00866	 B. WING			
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	12	2/01/2017
THE ESTA	TES AT TWIN RIVERS L	LC	MONT STREET MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
2 570	program and PU treat R15's pressure ulcer 10/13/17 indicated R gluteal, seen by woul treatment per order, a was incontinent of bo assistance with turnin scale (scoring system PU) was 14 (moderat breakdown. Although for R15 was turned at frequency was not id R15's care plan print was at risk for PU de of stage 3 and 2 press stage 2 PU on his co conduct a weekly ski pressure reducing cu apply barrier cream at and turn and reposition assessment. Although there was a turning at this was not added to During interview on 1 stated (R15's) care p	and was on a hydration the program. care area assessment, 15 has a stage 2 PU to right nd nurse practitioner, air mattress to bed. Resident wel and bladder, needs ng and repositioning. Braden in to determine risk level for te risk) risk for further in the assessment identified nd repositioned, but the entified. date 12/1/17 identified R15 velopment and had a history soure ulcers with a current ccyx. Staff were directed to in assessments, provide ishion in chair, and bed, after incontinence, toilet plan on schedule per h the assessment identified and repositioning schedule,	2 570			
	heat failure (CHF), m pain, chronic kidney	es of chronic congestive ajor depression, chronic diease, anemia, and on, undated facility face				

	TOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		00866	B. WING		12/01/2017	
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE	12	
THE ESTA	TES AT TWIN RIVERS L	305 FRE	MONT STREET			
		ANOKA	, MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
2 570	Continued From page	e 16	2 570			
		•				
	R26 was admitted to the hospital during the first day of survey (11/28/18) and returned to the facility the last day of survey (12/01/17).					
	In review of R26's ca 8/03/17), it was noted identified the two follo monitoring medicatio	owing concerns for				
	Coumadin (a blood th process of DVT [deep pulmonary embolism The intervention sect	n Anticoagulant therapy hinner) r/t [related to: diease p vein thrombosis], I [blood clots to the lungs]." tion directed staff to monitor of bleeding, and medications				
	drug reactions] r/t [re psychotropic medicat antidepressant) for th The staff were directe medication for discor	tion. Receives Cymbalta (an ne diagnosis of depression." ed to being tapering the ntinuation, and update the hysician assistant) regarding				
	10/26/17, there was a receiving either Cour review, it was docum received an order on Cymbalta to 60 millig that it was OK to disc 2 week if symptoms of	hysician's orders, dated no indication that R26 was madin or Cymbalta. In further hented that the facility 8/15/17 to decrease the grams (mg) everyday, and continue this medication after do not return. The facility 10/11/17 to discontinue the				

	OF DEFICIENCIES OF CORRECTION	1 (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION		E SURVEY PLETED	
		00866	B. WING		12	12/01/2017	
NAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
THE ESTA	TES AT TWIN RIVERS L	LC	MONT STREET MN 55303				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 570	Continued From page	e 17	2 570				
	Coumadin medication	۱.					
	director of nursing (D plan was not revised both the Coumadin an A policy on care plan	2/01/17 at 8:30 a.m., the ON) stated that R26's care after the discontinuation of nd Cymbalta medications. revisions was requested					
	and was not provided	D OF CORRECTION:					
	The director of nursin develop and impleme related to care plan re designee, could provi staff related to the tim	g (DON) or designee, could ent policies and procedures evisions. The DON or de training for all nursing					
	TIME PERIOD FOR ( (21) days.	CORRECTION: Twenty-one					
2 850	MN Rule 4658.0520 S Proper Nursing Care;	Subp. 2 D Adequate and Shaving	2 850			1/10/18	
	proper care. The crit adequate and proper D. Assistance wit						
	by: Based on observatior review, the facility fail	t is not met as evidenced n, interview and document ed to ensure shaving was sidents (R15) in the sample		corrected			

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STATEMEN	a Department of Health FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
	00866		B. WING		12	/01/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
THE ESTA	TES AT TWIN RIVERS LI	LC	MONT STREET MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
0.050			0.050	DEFICIEN		
2 850		upon staff for assistance	2 850			
	Findings include:					
	10/2/17, identified R1	m Data Set (MDS) dated, 5 had severe cognition extensive to total assistance ly living, and had no				
	had a physical function care impairment and	date 12/1/17, identified R15 oning deficit related to self ability with ADL's can vary. provide personal hygiene				
	his bed watching tele- communicate and had 11/29/17, at 5:56 p.m unshaven with visible 6:49 a.m. R15 was in for the day. He was u facial hair approximat p.m. R15 was in bed visible facial hair and past few days. On 12	n 11/28/17, at 10:08 a.m. in vision, he was unable to d visible facial hair. On . R15 was at nursing station facial hair. On 11/30/17, at his wheelchair and dressed nshaven and had visible tely 1/8 inch long. At 12:30 watching television with had not been shaved for the /1/17, at 8:58 a.m. R15 vith visible facial hair and left mately 10:00 a.m.				
	responsible for (R15's assistants (NA's) are whenever he has "lots NA-H who was R15's shaves [R15] when he	se (LPN)-E stated they were s) shaving and the nursing				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
		00866				40/04/0047	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	ZIP CODE	14	2/01/2017	
THE ESTA	ATES AT TWIN RIVERS L	LC	MONT STREET MN 55303				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 850	They do not shave hi needed because he p shave him." During th took care of him on T did not shave him be face touched. Review of the facility one person physical hygiene which includ documentation from identified check mark days and evening sh hygiene was complet On 12/1/17, at 12:35	m every day, only when it is bulls away when we try to his time NA-G stated she hursday (11/30/17) and she cause he doesn't like his Point Of Care form identified assistance with personal ed shaving. Review of the 11/18/17, to 12/1/17, us were in place for both fifs which identified personal	2 850				
	residents. SUGGESTED METH The director of nursin review/revise policies ensuring staff provide						
	TIME PERIOD FOR days.	CORRECTION: Twenty (21)					
2 855	MN Rule 4658.0520 Proper Nursing Care	Subp. 2 E. Adequate and Oral Hygiene	2 855			1/10/18	
	Subp. 2. Criteria for proper care. The cri adequate and proper	-					

STATE FORM

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00866			12/01	1/2017
AME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, ST	ATE, ZIP CODE		
HE ESTA	TES AT TWIN RIVERS	LLC	MONT STREET , MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLE DATE
2 855	Continued From page	ge 20	2 855			
	keep the mouth, tee	eeded with oral hygiene to th, or dentures clean. used to prevent dry, cracked				
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure oral cares were offered or provided for 2 of 5 residents (R39, R15) in the sample who were dependent upon staff for assistance with activities of daily living (ADLs).			corrected		
	Findings include:					
	Minimum Data Set ( 9/27/17, included ce (stroke) with left her required extensive a ADLs. The MDS als cognition. A care are ADLs, dated 9/27/16 assistance with dres The care plan, revis	s identified on the annual MDS) assessment dated prebral vascular disease niplegia, and identified R39 assistance of staff to complete o indicated R39 had intact ea assessment (CAA) for 5, indicated R39 required assing, grooming and bathing. ed 7/12/17, identified R39 ioning deficit, but was able to t up.				
	nurse (LPN) checke room. The LPN the milk and jelly to eat sugar. At 8:22 a.m., re-check the blood s nursing assistant (N morning cares. NA-I towels and clothing	I a.m., a licensed practical d R39's blood sugar in his n provided R39 with some in response to the blood LPN-A entered R39's room to sugar, and left the room when A)-B greeted R39 to begin B gathered care supplies, and began R39's morning ed and dressed R39, then				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
	00866		B. WING		12	2/01/2017
IAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
HE ESTA	TES AT TWIN RIVERS L	LC	MONT STREET MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 855	Continued From page	e 21	2 855			
	lots of residents to as offer R39 oral cares s tooth brushing." NA-E	D p.m., NA-B stated she had ssist this morning and did not stating, "I just forgot to offer 3 also stated R39 was to complete his cares.				
	stated the care plan s should be offered and teeth. LPN-A stated	1/30/17, at 1:02 p.m., LPN-A should be followed and R39 d assisted as need to do his staff need to try, and try eded. LPN-A added R39's d have been done."				
	director of nursing (D oral cares should be	12/1/17 at 8:49 a.m., the ON) stated at a minimum, offered in the morning and rated she expected oral				

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED					
	00866	B. WING		12	2/01/2017				
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE									
TES AT TWIN RIVERS L	LC								
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE				
cares needed to be or refused, staff should caregiver attempt car A facility document, or identified the purpose procedure was to cle mouth, remove food to maintain the teeth condition, to prevent to keep the resident's The Policy directed s indicated on the resident SUGGESTED METH The director of nursin direct care staff regan hygiene. The DON of	offered to residents. If reapproach or have another res. Dral Hygiene, dated 2/15, e of the [Oral Care] an and freshen resident's particles form between teeth, and gums in a healthy infections of the mouth and s lips and oral tissues moist. taff to offer oral hygiene as dent's plan of care.	2 855							
<ul> <li>(21) days.</li> <li>MN Rule 4658.0525 Motion</li> <li>Subp. 2. Range of m that is directed towar through positioning a implemented and ma comprehensive resid of nursing services m</li> </ul>	Subp. 2.B Rehab - Range of notion. A supportive program d prevention of deformities nd range of motion must be iintained. Based on the ent assessment, the director nust coordinate the	2 895			1/10/18				
	ROVIDER OR SUPPLIER TES AT TWIN RIVERS L SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page cares needed to be or refused, staff should caregiver attempt car A facility document, O identified the purpose procedure was to cle mouth, remove food to maintain the teeth condition, to prevent to keep the resident's The Policy directed s indicated on the resident's MN Rule 4658.0525 Motion Subp. 2. Range of m that is directed towar through positioning a implemented and ma comprehensive resid of nursing services m development of a nur-	DF CORRECTION       IDENTIFICATION NUMBER:         00866       O0866         ROVIDER OR SUPPLIER       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 22       cares needed to be offered to residents. If refused, staff should reapproach or have another caregiver attempt cares.         A facility document, Oral Hygiene, dated 2/15, identified the purpose of the [Oral Care] procedure was to clean and freshen resident's mouth, remove food particles form between teeth, to maintain the teeth and gums in a healthy condition, to prevent infections of the mouth and to keep the resident's lips and oral tissues moist. The Policy directed staff to offer oral hygiene as indicated on the resident's plan of care.         SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could educate direct care staff regarding expectations for oral hygiene. The DON or designee could develop auditing systems to monitor for ongoing compliance.         TIME PERIOD FOR CORRECTION: Twenty-one (21) days.         MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion         Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which	or correction       identification NUMBER:       A. BuildDing:         nose6       B. Wing         ROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE         TES AT TWIN RIVERS LLC       305 FREMONT STREET ANOKA, MN 55303         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG         Continued From page 22       2 855         cares needed to be offered to residents. If refused, staff should reapproach or have another caregiver attempt cares.       2 855         A facility document, Oral Hygiene, dated 2/15, identified the purpose of the [Oral Care] procedure was to clean and freshen resident's mouth, remove food particles form between teeth, to maintain the teeth and gums in a healthy condition, to prevent infections of the mouth and to keep the resident's lips and oral tissues moist. The Policy directed staff to offer oral hygiene as indicated on the resident's plan of care.         SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could educate direct care staff regarding expectations for oral hygiene. The DON or designee could develop auditing systems to monitor for ongoing compliance.       2 895         TIME PERIOD FOR CORRECTION: Twenty-one (21) days.       2 895         Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which	OF CORRECTION       IDENTIFICATION NUMBER:       A BUILDING:         00866       B WING         CONDER OR SUPPLIER       STREET ADRESS, CITY, STATE, ZIP CODE         305 FREMONT STREET       ANOKA, MN 55303         SUMMARY STATEMENT OF DEFICIENCIES       ID         (EACH DEFICIENCY WINT BE PRECEDED BY FULL       ID         REGULATORY OR LSC IDENTIFYING INFORMATION)       PRECK         Continued From page 22       2 855         cares needed to be offered to residents. If       refused, staff should reapproach or have another         cares needed to be offered to resident's       mouth, remove food particles form between teeth,         to condition, to prevent infections of the mouth and       to face the and gums in a healthy         condition, to prevent infections of the mouth and       to keep the resident's lips and oral tissues moist.         The Policy directed staff to offer oral hygiene as       indicated on the resident's plan of care.         SUGGESTED METHOD OF CORRECTION:       The bollow offer oral hygiene as         The Nolicy directed staff to offer oral hygiene as       2 895         MIN Rule 4658.0525 Subp. 2.B Rehab - Range of       2 895         Subp. 2. Range of motion. A supportive program that is directed toward preventine of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident asessment, the director of nursing services must coordi	FCORRECTION       IDENTIFICATION NUMBER:       A. BUILDING:				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00866		B. WING		12/01/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
THE ESTA	TES AT TWIN RIVERS L	LC	MONT STREET MN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
2 895	Continued From page	e 23	2 895		
		treatment and services to ption and to prevent further motion.			
	by: Based on observation review the facility fail and a nursing rehabil	nt is not met as evidenced n, interview and document ed to provide hands splints litation functional n for 1 of 2 resident (R15) in		corrected	
		limited range of motion.			
	10/2/17, identified R1 impairment, needed for all activities of dai lower extremity impa	Im Data Set (MDS) dated, 15 had severe cognition extensive to total assistance Ily living (ADL's), no upper or irments, had no rejection of no mention of a nursing n.			
	sheets (form that iden for each resident), ur ADL's were "Right ha in AM [morning]." The	Team #4, nursing assistant ntified what cares to provide ndated, identified R15's and splint on when in bed, off ere was no mention of any program on the sheet.			
	was wheeled into his (RN)-A and motioned help assist with perso R15 face, while wash his face away and us NA-A away. R15 did	n 11/29/17, at 8:04 p.m. R15 room by registered nurse I nursing assistant (NA)-A to onal cares. NA-A washed ning his face R15 was turning sing his left hand to push not raise his right hand by in his lap. R15 made no			
	attempts to move his	right hand. RN-A gave R15 bld with his left hand and			

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
0		00866	B. WING		12	2/01/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
THE ESTA	ATES AT TWIN RIVERS L	LC	MONT STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ANONA, ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
2 895	on his incontinent bri move his right hand v lap. After cares were RN-A and NA-A left ti attempts to provide a they place a splint or interview at 8:46 p.m did not have any nurs a splint that went on shift was responsible During observation o was up and dressed stated she got R15 u cares. She had to ho pushed them away d R15 was supposed to hand, but he did not l she arrived to work. Review of R15's Occ dated 9/26/16, identifi hemiparesis (paralys trace movement of hi range of motion in ell within functional limit when should flexion p Review of a Therapy 10/31/16, identified F at hour of sleep and to morning cares. The facility Therapy ( 12/1/16, identified fur program (FMP) provi	and to keep R15 from pulling ef. R15 made no attempts to which continued to lay in his completed at 8:45 p.m. he room. They made no iny range of motion, nor did n R15's right hand. During . NA-A stated the resident sing rehab program but had his right hand which the night for. n 11/30/17, at 6:49 a.m. R15 ready for the day. NA-F p and provided personal ld his left hand because he uring cares. NA-F stated to have a splint on his right have it on this morning when upational Therapy (OT) note, fied R15 had right is right side of body) with is right fingers, no active pow or shoulder, and PROM ed with verbalization of pain		DEFICIE	NCY)	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			SURVEY PLETED
		00866		B. WING		12/01/2017
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,		12	/01/2017
	TES AT TWIN RIVERS	305 FRE	MONT STREET			
	TES AT TWIN RIVERS	ANOKA	, MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE
2 895	Continued From page	ge 25	2 895			
	identified nursing to	ummary, dated 12/2/16, continue right upper right hand splinting schedule uring the day.				
	9/25/17, identified bi passive range of mo limits. Limited range hemiparesis/brain in was on a functional	cupational therapy note, ilateral upper extremity otion (PROM) within functional of motion related to ujury. Nursing reports R15 maintenance program (FMP) rom previous therapy in				
	identified a FMP wa	y note dated 10/3/17, s in place and to continue the ot changed or declined.				
	problem with physic mobility impairment,	nt date 12/1/17, identified a al functioning related to but did not address the use t or any restorative nursing				
	record (TAR) from 9	y treatment administration /17, through 11/17, did not f motion, or any hand splint the record.				
	occupational therapy	12/1/17, at 8:13 a.m. certified y assistant (COTA)-A stated R15 had any FMP PROM I any hand splints.				
	stated she has never resident. He had blu has never heard tha motion (ROM). She	12/1/17, at 11:23 a.m. LPN-E er seen a hand splint on the le boots but no splints and t (R15) received any range of stated there were no edication or treatment records				

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STATEMENT	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00866	B. WING		12	2/01/2017
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
THE ESTA	TES AT TWIN RIVERS L	LC	MONT STREET , MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 895	Continued From page	e 26	2 895			
	or care plan for the h	and splint or ROM.				
	stated the resident ha wear it anymore. NA hand splint, and wen the splint in the top d wore the splint at nig not have it on, nor d (12/28/17) morning w Frequently he did not worked. Evenings are	2/1/17, 11:27 a.m. NA-H ad a hand splint, but did not I-I stated R15 had a right t into his room, and located rawer of his night stand. He ht, but this morning he did id he have it on on Tuesday when she took care of him. t have it on when she e suppose to place it on him , but this frequently did not				
	Physical Therapy (DI therapy notes for R13 documentation, R15 maintenance program The last therapy note was still on a FMP with right hand. DPT state created a FMP and m program. If they had change the FMP they therapy. There was m	n with PROM on 3/16/17. e on 10/3/17, identified he ith PROM and had a splint to ed the therapy department sursing was to follow this questions or they wanted to y needed to consult with no mention that R15's FMP or d been stopped so he should				
	(DON) stated she wa hand splint, but did n PROM program and DON reported R15's right hand splint or th	p.m. director of nursing as aware R15 had a right ot know R15 had a FMP needed to look into this. The care plan did not identify the le FMP PROM program uded as part of the care plan.				
		IOD OF CORRECTION: The ON) or designee could				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION	(X3) DATE SURVEY COMPLETED				
00866		00866	B. WING		12/01/2017				
IAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE					
THE ESTATES AT TWIN RIVERS LLC       305 FREMONT STREET         ANOKA, MN 55303									
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE			
2 895	devise a communicat of Therapy or designe processes regarding programs. The direct designee could inserv implementation of the completing range of r audit to ensure comp	ion system with the Director ee to ensure communication nursing rehabilitation or of nursing (DON) or vice nursing staff regarding e care plan to include notion as directed, and then	2 895						
2 900	Ulcers Subp. 3. Pressure so comprehensive reside of nursing services m development of a nur provides that: A. a resident who without pressure sore pressure sores unless condition demonstrate authenticates, that the B. a resident who receives necessary t promote healing, prev new sores from devel This MN Requiremen by: Based on observatio review the facility faile current pressure ulce	ent assessment, the director ust coordinate the sing care plan which enters the nursing home es does not develop s the individual's clinical es, and a physician ey were unavoidable; and o has pressure sores reatment and services to vent infection, and prevent loping. t is not met as evidenced n, interview and document ed to ensure residents with	2 900	corrected		1/10/18			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			SURVEY PLETED
		00866	B. WING		12	/01/2017
AME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
HE ESTA	TES AT TWIN RIVERS	LLC	MONT STREET , MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 900	Continued From pag	ge 28	2 900			
	pressure ulcers.					
	Findings include:					
	10/2/17, identified R impairment, needed for all activities of da pressure ulcer (PU) current stage 2 PU ( dermis presenting a red-pink wound bed received treatments	um Data Set (MDS) dated 15 had severe cognition extensive to total assistance aily living, was at risk for development, and had a (Partial thickness loss of s a shallow open ulcer with a ). The MDS indicated R15 of pressure reduction d and was on a hydration atment program.				
	5:56 p.m. to 8:04 p.r. timely. At 5:56 p.m. evening meal and w station watching oth medications. Licens was preparing the m sport to R15. At 6:05 his chair waiting for until 6:26 p.m. when room for medication feeding and was wh station at 6:37 p.m. He remained in his station until 7:27 p.m assistant (NA)-A if h did not respond. NA	bservation on 11/29/17, from m., R15 was not repositioned R15 had just finished his ras sitting at the nursing ers while waiting for his ed practical nurse (LPN)-D hedications and talking about 9 p.m. R15 remained sitting in the nurse and remained there a LPN-A wheeled R15 to his administration via tube eeled back to the nursing without being repositioned. wheelchair at the nursing n. when asked by nursing e wanted to go to bed. R15 A-A wheeled R15 half way nd left him in the hallway.				
	NA-A brought a med and then left again w the hallway. At 7:29 the nursing station a until 7:41 p.m. when	chanical lift into R15's room while R15 remained sitting in p.m. he was wheeled back to and left. He remained there he was again wheeled half ay and left in the hallway. He				

Minnesota Department of H STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		B. WING			
	00866			12	2/01/2017
NAME OF PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE E <b>MONT STREET</b>	, ZIP CODE		
THE ESTATES AT TWIN RIVER	RS LLC	, MN 55303			
PREFIX (EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETI DATE
2 900 Continued From	page 29	2 900			
assisting other re snacks. At 8:04 p wheeled R15 into assist the residen RN-A and NA-A p was incontinent of were pink. There coccyx where the approximately .2 surrounding the a incontinent of sm movement. RN-A very small and ha During interview f NA-A stated R15 "4:00 ish", then st around 7:00 p.m. p.m.", more than he should be turn hours. Review of the fact which were used provide care and identified R15 new every 2 hours, but frequently R15 new repositioned ever pressure ulcer. R15's care plan p was at risk for PL of stage 3 and 2 p stage 2 PU on his conduct weekly s pressure reducing	allway while staff walked by, sidents and passing out evening .m. registered nurse (RN)-A his room and motioned NA-A to t to bed. With a mechanical lift provided personal cares. R15 f bowel and bladder his buttocks was an indentation on his PU was located which was cm in size with pink tissue trea. NA-A stated he was all amount of urine and bowel stated the PU looked good, was id been improving. following cares at 8:46 p.m. was last repositioned around tated he was repositioned then stated it was "around 4:00 4 hours ago. She further stated ed and repositioned every two ility's undated Team 4 sheets, by the nursing assistants to is part of the facility care plan, eded assistance with toileting t there was no indication of how eeded to be turned and in though he had a current rint date 12/1/17 identified R15 d evelopment and had a history pressure ulcers with a current a coccyx. Staff was directed to kin assessments, provide g cushion in chair, and bed, im after incontinence, toilet plan				

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STATEMENT	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00866	B. WING		12/01/2017	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	·	
THE ESTA	TES AT TWIN RIVERS L	LC	MONT STREET MN 55303			
	SUMMARY ST	TATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF		(ME)
(X4) ID PREFIX TAG	(EACH DEFICIENC	LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
2 900	Continued From pag	e 30	2 900			
	to right gluteal, seen treatment per order, i was incontinent of bo assistance with turnin scale (scoring system PU) identified a mode breakdown. Although assessment identified repositioned per asse this was not identified Review of R15's wee 11/28/17, identified R on his coccyx was im the note identified the centimeters in size a R15's right lower but During interview on 1 stated R15's care pla turning and reposition be. During interview on 1 above information was of nursing, who indic turning and reposition SUGGESTED METH director of nursing or staff responsible for g following the care pla promote healing and from developing. The designee could then care and serves were	by wound nurse practitioner, air mattress to bed. Resident owel and bladder, needed ing and repositioning. Braden in to determine risk level for erate risk for further in the care plan and d R15 was to be turned and essment, the frequency of d. ekly skin notes from 10/17, to R15 had a stage 2 PU located inproving in size. On 11/28/17, e PU measured .2 and staff were to monitor tocks near his brief line. 11/30/17, at 2:00 p.m. LPN-E an was not specific for a ning schedule but it should 12/1/17, at 12:35 p.m. the as reviewed with the director ated they needed to follow a ning schedule for (R15). HOD OF CORRECTION: The designee could in-service all giving cares/services on an exactly as directed to prevent pressure ulcers e director of nursing or conduct audits to ensure				
	(21) days.					

STATEMENT	a Department of Health OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		00866	B. WING		12/01/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
THE ESTA	TES AT TWIN RIVERS LI	LC	MONT STREET MN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
21385	Continued From page	31	21385		
21385	MN Rule 4658.0800 S Staff assistance	Subp. 3 Infection Control;	21385		1/10/18
	Personnel must be as infection control progr	ance with infection control. ssigned to assist with the ram, based on the needs of sing home, to implement edures of the infection			
	by: Based on observation review the facility faile handwashing and glo for 1 of 5 residents (R cares. In additional th management program	ve usage was implemented (15) observed for personal e faciltiy lacked a water n for the prevention of the potential to affect all 43		corrected	
	Findings include:				
	HANDWASHING and	GLOVE			
	11/29/17, at 8:04 p.m (RN)-A wheeled R15 nursing assistant (NA bed. NA-A and RN-A mechanical lift to tran into bed. Once in bed placed gloves on and washcloth. NA-A reme product, which was so R15's perineal area. S	sfer him from the wheelchair d NA-A removed the sling washed R15's legs with a oved R15 incontinent biled with urine then washed She removed her gloves her hands donned a new			

STATEMENT	a Department of Healt FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		00866	B. WING		12/01/2017	
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
THE ESTA	ATES AT TWIN RIVERS L	305 FRE	MONT STREET			
		ANOKA,	, MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETI DATE
21385	Continued From pag	e 32	21385			
	with a disposable clo movement which NA NA-A used the same incontinence brief on adjusting his gown, b on a pillow without re NA-A continued with placed heel protector soiled clothing and o She washed R15's b the drawer of R15's r soiled gloves. During interview on 1 R15's cares were con she did not change h hands between glove The above informatio director of nursing or additional information Review of the facility Handwashing, undat Indication for Hand H identified as; before a resident, after contact excretions, mucous r and wound dressing LACK OF WATER M FOR FOR LEGIONE	th. R15 had a small bowel -A cleaned. When finished soiled gloves and placed an R15, touching R15's pillow, bedding and placed his feet emoving the soiled gloves. the same soiled gloves and rs on R15, picked up R15's pened the bathroom door. asin and placed the basin in hightstand, then removed the 11/29/17, at 8:46 p.m. after mpleted, NA-A was unaware the soiled gloves or wash her e usage. on was discussed with the h 12/1/17, at 12:30 a.m., no h was provided. policy entitled, ed, identified procedure B: Hygiene/Handwashing were and after direct contact with et with body fluids or membranes, non-intact skin and after removing gloves. ANAGEMENT PROGRAM				
	control program, esp surveillance and trac the facility. The DON policy" regarding pre	as in charge of the infection ecially the day-to-day king of resident infections in V knew the facility "had a venting the spread of d she was not aware of the				
	water management a mechanics of the fac	assessment, or the ility's monitoring of the water				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			SURVEY PLETED
		00866			12	/01/2017
AIVIE OF Pr	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, E <b>MONT STREET</b>	ZIP CODE		
HE ESTA	TES AT TWIN RIVERS	LLC	, MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21385	Continued From page	ge 33	21385			
	Legionella. The DC current Legionella-r	ne potential start or spread of DN stated the facility had no elated pneumonia infections.				
	Program, undated, i can cause a serious (Legionnaire's Disea that outbreaks have maintained water sy complex water syste long-term care facili	jionella Water Management indicated Legionella infections is type of pneumonia ase) in persons at risk, and be been linked to poorly ystem in building with large or ems, including hospitals and ities. The policy indicated the t Program included key				
	Legionella and othe pathogens could gra - implementing a wa including control me environmental testir - testing protocols, a measures, document	assessment to identify where or opportunistic waterborne ow and spread; ater management program easures, inspections and ng for pathogens; and acceptable ranges of control ntation of results and aken when control limits are				
	Developing a Water Reduce Legionella dated 6/5/17, indica a serious type of pn called Legionella that can make people si contaminated water that are not adequa Implementing a wat	e Control (CDC) document, Management Program to Growth & Spread in Buildings, ted Legionnaire's disease was neumonia caused by bacteria, at live in water. Legionella ck when they inhale from building water systems tely maintained. er management program can risk for growing and spreading				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
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	ROVIDER OR SUPPLIER	00866	DDRESS, CITY, STATE,		12	2/01/2017
	TES AT TWIN RIVERS L	305 FRE	MONT STREET			
	IES AT TWIN RIVERS L	ANOKA,	MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21385	Continued From page	e 34	21385			
	<ul> <li>Continued From page 34</li> <li>facility administrator stated the facility "did not have" a formal water management program in response to Legionella. The administrator stated there was a corporate policy in place, and the facility did the first part of the CDC "toolkit" assessment, which determined the need for a water management plan, and there were also some bath cleaning policies. The administrator stated the facility had not completed a full assessment, or analyzed the building's water supply and tubs, or had a monitoring plan. The administrator stated we need a program and "we are working toward it."</li> <li>A facility policy, Infection Prevention and Control Program, dated 8/17, indicated important facets of infection prevention included "following established general and disease-specific guidelines such as those of the Centers for Disease Control (CDC).</li> </ul>					
	The director of nursin develop, review, and procedures to ensure and standards are ma appropriate. The DOI all appropriate staff o	OD OF CORRECTION: og (DON) or designee could for revise policies and infection control procedures aintained by all staff as N or designee could educate n the policies/procedures, onitoring systems to ensure				
	Twenty-One (21) Day					
21426	MN St. Statute 144A. Prevention And Contr	04 Subd. 3 Tuberculosis rol	21426			1/10/18
	(a) A nursing home	provider must establish and				

STATE FORM

23SE11

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			B. WING			
		00866			12/01/2017	
IAME OF PI	ROVIDER OR SUPPLIER		.DDRESS, CITY, STA MONT STREET	IE, ZIP CODE		
THE ESTA	TES AT TWIN RIVERS L	LC	MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLET	
21426	Continued From page	e 35	21426			
	current tuberculosis in issued by the United Control and Prevention Tuberculosis Eliminat Morbidity and Mortali This program must in infection control plan unpaid employees, cor residents, and volunt Health shall provide to regarding implementat	ram according to the most nfection control guidelines States Centers for Disease on (CDC), Division of tion, as published in CDC's ty Weekly Report (MMWR). Include a tuberculosis that covers all paid and ontractors, students, eers. The Department of technical assistance ation of the guidelines.				
	by: Based on interview a facility failed to ensur (TST) or chest rays w results documented f (NA-K, TMA-B) review	nt is not met as evidenced nd document review, the re a tuberculosis skin tests vere conducted and the for 2 of 5 new employees wed for tuberculosis (TB) d by the Centers for Disease on.		corrected		
	identified NA-K was h symptom screen for 7 second step TST was 5/17/17, was negative	A)-K's employee record hired on 9/20/17, and had a TB on 9/20/17. A first and s completed on 5/4/17 and e with 0 millimeters nployment at the facility. The				

STATE FORM

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00866	B. WING		10/04/0047	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	12	2/01/2017
THE ESTA	TES AT TWIN RIVERS L	LC	MONT STREET			
		ANOKA,	MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21426	Continued From page	e 36	21426			
	director of nursing stated on 11/30/17 at 1:00 p.m. NA-K's TST was completed by a previous employer. She was unaware only one of the TST's counted for TB screening and they needed to complete the second step for the TST, which was not completed.					
	and had a symptom s The form identified T complete a TST beca positive TST. There w had a current chest X from TB. The admini 12:40 p.m. that TMA- facility and was no lo TMA-A's time sheets identified TMA-A work	ed she was hired on 8/1/17, screen for TB on 7/17/17.				
	Worker policy, undate workers will receive b includes a written ass If the employee has w TST within 12 months counted as a 1st step receive a second step from date of hire. If th positive TST, a chest	esis Screening Health Care ed, indicated all health care baseline TB screening, which sessment, and a 2 step TST. written proof of a negative of s of employment, this will be o TST. The employee will p TST one to three weeks the employee has a history of t x-ray will be taken and the Tuberculosis Screening ed by a physician.				
	Director of Nursing or review, and/or revise	OD OF CORRECTION: The r designee could develop, policies and procedures to screening and testing is done				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00866	B. WING		12	/01/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
THE ESTA	TES AT TWIN RIVERS L	LC	MONT STREET			
		ANUKA,	MN 55303	PROVIDER'S PLAN OF CC	DRECTION	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
21426	Continued From page	9 37	21426			
	The Director of Nursin educate all appropriat procedures. The Dire could develop monito ongoing compliance.	to regulations upon hire. ng or designee could te staff on the policies and ctor of Nursing or designee ring systems to ensure CORRECTION: Twenty-one				
21435	MN Rule 4658.0900 S Recreation Program;		21435			1/10/18
	home must provide an recreation program. based on each individ strengths, and needs meet the physical, me well-being of each res comprehensive reside comprehensive plan of 4658.0400 and 4658 provided opportunities	of care required in parts .0405. Residents must be				
	by: Based on observatior review, the facility fail	t is not met as evidenced n, interview and document ed to provide meaningful sidents (R1, R15) who were r activities.		corrected		
	Findings include:					
	R1's admission Minim indicated R1 had no s	num Data Set dated 8/17/17, speech, was rarely				

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00866	B. WING		12	/01/2017
AME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	ZIP CODE		
HE ESTA	TES AT TWIN RIVERS L	LC	MONT STREET MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21435	Continued From pag	e 38	21435			
	activities indicated the important to R1. The total assistance to tra- assistance with locor Diagnoses included understand or express damage) stroke and activities Care Area A 8/23/17, indicated a activities related to R and a native language indicated R1 was una things at this time du communication. Fam previously participate his rest. The CAA ince developed as R1 wa decline due to lack o activity needs and de recreation department stimulating environm indicate what types of would be provided to	f interview of family about here were no activities MDS indicated R1 needed ansfer and extensive motion on the unit. aphasia (loss of ability to as speech, caused by brain schizoaffective disorder. R1 Assessment (CAA) dated potential problem for R1's inability to communicate ge of Arabic. The analysis able to perform and do many e to his lack of hily indicated he did not e in any activities and needed dicated a care plan was to be s at risk complications and f ability to communicate esires and therapeutic nt would provide R1 with a ent. The CAA did not of stimulation or activities				
	8/14/17, indicated R attended church and assessment indicate had a poor attention	1 was a very social person, enjoyed traveling. The d R1 was withdrawn, and span and did not address d provide activities or				
	altered socialization communicate. Goals continue daily indepe and participate in sho	11/10/17, indicated R1 had due to the inability to for R1 included R1 would endent activities in his room ort one on one weekly visits. d providing R1 with with				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00866	B. WING		12	2/01/2017
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
THE ESTA	TES AT TWIN RIVERS L	LC	MONT STREET MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE ) THE APPROPRIATE	(X5) COMPLET DATE
21435	Continued From page	e 39	21435			
	stimulating music, tel	evision and other activities.				
	indicated R1 was limit cognitive and physical indicated therapeutic assistants had provid Quran (Islamic religion as turning on the tele around the facility via during the last quarter activity goals were m R1's activity document following: 9/17 - R1 h activities were docum family visits, and three were opened for sense had 10 family visits, t	recreation staff and nursing ed R1 with readings of the sus text) on a tablet as well vision to soccer, wheeling wheelchair and family visits r. The review indicated R1's et. htation indicated the ad 17 family visits, no other nented. 10/17 - R1 had nine e times the window shades sory stimulation. 11/17 - R1 wice up in the wheelchair in evision with the soccer game				
	to 2:28 p.m. R1 was l without any music, te staff aside from requi	on 11/28/17, from 9:00 a.m. ying in bed with the lights on levision or interaction from red care (medications, ning) services from staff.				
	member (FM)-A state almost a daily basis, without any music or would be nice if he w occasionally even if h	1/28/17, at 2:30 p.m. family of when the family visited, on R1 was always lying in bed television. FM-A stated it as up and around people le could not participate in d R1 also liked to be outside,				
anosoto Doi	to 6:20 p.m. R1 was I	on 11/29/17, from 1:00 p.m. ying in bed. The lights were , television or interaction				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00866	B. WING		12	2/01/2017
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
THE ESTA	ATES AT TWIN RIVERS L	LC	MONT STREET MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
21435	Continued From pag	e 40	21435			
		required care (medications, ning) services from staff.				
	assistant (NA)-J state	11/29/17, at 7:43 p.m. nursing ed R1 spent most of his time 't have music or a television n.				
	During observations on 11/30/17, from 6:54 a.m. through 12:37 p.m. R1 was lying in bed. The lights were on without any music, television or interaction from staff aside from required care (medications, turning and repositioning) services from staff.					
	E stated R1 was alwa participate in any stru terrible for him." NA-	n 11/30/17, at 12:24 a.m. NA- ays in bed and did not uctured activities. "I feel E was not aware of any R1 for any stimulation, other				
	licensed practical nur family visited about e occasionally when fa R1 up in a wheelchai him. The facility did r wheelchair unless fa requested this, as R the one on one wher stated R1 had a lack worker talked to famil	mily was here staff would get ir, so family could sit with				
	admission a therape completed which incl	2/1/17, at 8:09 a.m. director (TPD) stated on utic program evaluation was uded likes and dislikes. TPD nsive assessment was done				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED	
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		00866	B. WING		12	2/01/2017	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE			
THE ESTA	TES AT TWIN RIVERS L	LC	MONT STREET MN 55303				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21435	Continued From page	e 41	21435				
	evaluation was comp the only staff member and herself and volur the residents. TPD st stated R1 just needer have any activity inter received a tablet and play for R1 but had o Staff had also turned the television becaus soccer. TPD stated s his room for stimulati implemented one on November. TPD stated stimulation activities the family and no suc present as R1 could had not included occi determine stimulation conference was held interpreter and family music and activity pre- conversation should the facility could have without family input.	he opened the curtains in on and had just one activities with R1 in ed it was difficult to find for R1 with little input from ccess with an interpreter not speak. TPD stated she upational therapy to help activities for R1. A care the day before and the gave some more ideas on eferences, but added the have taken place earlier and e made attempts even					
	therapist (SLP) stated therapy services on S was for communication (difficulty swallowing) all of which were not therapy did not work	a.m. speech language d R1 was discharged from 0/27/17. The focus of therapy on in general, dysphasia and safety in a wheelchair successful. Occupation with R1 in activity/stimulation a referral from the facility to					
		2/1/17, at 10:27 a.m. ON) stated R1 was unsafe nair for activities, however;					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		00866	B. WING		12	2/01/2017	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE			
THE ESTA	TES AT TWIN RIVERS L	LC	MONT STREET MN 55303				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21435	Continued From page	e 42	21435				
	should have his curtains opened and some sort of noise stimulation through the day. DON stated the facility was relying on family to bring in music and did not try various music on their own. DON further stated the nursing assistants had not been instructed to provide any structured activities for R1 throughout the day.						
	7/09, provided a polic mission to promote d person and we offer a interest to all clients.' implementation state calendar is developed	buted to client." The policy					
	10/2/17, identified R1 impairment, needed for all activities of dai preferences were ide MDS identified R15's newspaper, music, an group of people, impo	m Data Set (MDS) dated 5 had severe cognition extensive to total assistance ly living, and activity intified by the resident. The preferences of books, nimals, news, being with ortant favorite activities, igious services were all not					
	R15 was in bed smili watching show Ocea with yes and no resp with these responses	n 11/28/17, at 10:08 a.m. ng, the television was on ns 11, able to communicate onse but was inconsistent s. At 12:05 p.m. he was in the or his meal to be served.					
	member (F)-A stated basketball, tennis as	/28/17, 4:15 p.m. family (R15) liked football, he was always a big sports sports trivia. He liked all					

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED	
				NG:			
		00866	B. WING		12	2/01/2017	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
THE ESTA	TES AT TWIN RIVERS L	LC	MONT STREET MN 55303				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES         ID         PROVIDER'S PLAN OF           (EACH DEFICIENCY MUST BE PRECEDED BY FULL         PREFIX         (EACH CORRECTIVE AC           REGULATORY OR LSC IDENTIFYING INFORMATION)         TAG         CROSS-REFERENCED TO           DEFICIENC         DEFICIENCE         DEFICIENCE		TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE			
21435	Continued From page 43 sports, and his favorite sports were hockey and then football. F-A stated the facility should put the television on any sports channel, so he can watch these. They were unsure if R15 attended any activities, they usually don't see him in activities when they visit him, but think the facility does some things with him.		21435				
	therapeutic program participated in bingo, for movies. He was I but liked the MN Wild She was unsure wha but would check. At 6 maintenance director brought from home. channels on it, now th	11/29/17, at 12:41 p.m. director (TPD) stated R15 social events, and came out limited because of dialysis, d hockey and MN Vikings. t his assessment identified 5:58 p.m. TPD stated the fixed R15's television, he The television only had five hat it was reprogrammed he hannels the facility offered e sports channels.					
	the nurses station was had a Twins t-shirt or (LPN)-D stated R15 I R15 smiled at LPN-D room either by the nu of the hallway until 8: brought to his room to activities occurring do R15 went to bed NA-	n 11/29/17, at 5:56 p.m. at aiting for his medication and n. Licensed practical nurse liked the MN Vikings and 0. R15 remained out of his ursing station or in the middle 04 p.m. when he was o go to bed. There were no uring this time of day. Once A turned the television on to but did not turn the TV to a					
	was waiting for his br NA-F was feeding hir a.m. R15 was placed liked soap operas, ca	n 11/30/17, 7:48 a.m. R15 reakfast and at 8:08 a.m. n without difficulty. At 8:45 l in bed and NA-G stated he artoons and sports. She has t not a lot he liked to watch					

	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00866	B. WING		12/01/2017	
NAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	•	
THE ESTA	TES AT TWIN RIVERS L	LC	MONT STREET MN 55303			
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN C		(X5)
PREFIX TAG	1	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TC DEFICIEI	D THE APPROPRIATE	COMPLETE DATE
21435	Continued From page	e 44	21435			
	television. NA-G was	unaware R15's television				
	channels had been re	eprogrammed so R15 could				
	•	urned the television on, and				
	-	ook for a sports channel.				
		ned on a news program.				
		television and left the room. room until the lunch meal				
	-	the same television station				
	on. Staff made no att					
		sports channel for R15.				
		e plan print date 12/1/17, did				
	not have any information about activity goals or					
	participation.	NALINA A stirity Doution stick				
		MHM Activity Participation 17, identified under the				
		cipation summary the				
	-	roup activities infrequently				
		dining room, snack cart and				
		lent enjoyed independent				
		tching TV and sports.				
		alysis three times a week				
		ation. Resident's favorite				
		ied as preferring visits from ent activities. Resident				
	•	orts. Resident was proud of				
		an. The activity plan review				
		mained appropriate/current				
		al was met and interventions				
	were effective in read	ching goal.				
	The facility had a Lei	sure Request Form,				
	•	ed R15 was interested in				
		n parenthesis Christian,				
		rts which include Vikings,				
		s computer games/lesson,				
		and animals. The form also bbies of going out to eat,				
	Frisbee gold, throwin					

STATEMENT	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE COMF	SURVEY	
				A. BUILDING:			
		00866	B. WING		12	01/2017	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
THE ESTA	TES AT TWIN RIVERS L	LC	MONT STREET MN 55303				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE	
21435	Continued From page	e 45	21435				
21400	The activity participat to November 2017, ic was involved in: 8/17: meals 13 days, hospitalized 13 days 9/17: meals 19 days; TV/radio: 19 days; ex 1 day 10/17: meals 22 days 22 days, spiritual visit participation in game days and social even 11/17: meals 18 days day; TV/radio 18 days day; TV/radio 18 days Refused games 4 day events 1 day. Review of the data id his days watching tel- involved in 13 days of spiritual visits, social August to November During interview on 1 stated they did a qua participation before h annual evaluation un- On a monthly basis h	tion forms from August 2017, dentified activities that R15 TV/radio: 9 days and was conversation 2 days, tercise 1 day; spiritual visits s; social events 2 days; TV ts 4 days. Refused s, 4 days; currents events; 2 t 1 day s, music 1 day; social event 1 s, spiritual visits 3 days. ys and refused current entified R15 spent most of evision, and was only of other events that included events, and exercise from 2017, 111 days. 2/1/17, 11:41 a.m. TPD rterly review of his activity is care conference, and an der section F of the MDS. is participation was tracked,					
	meals and there was counted as an activity was limited due to his week. TPD was unaw	y for R15. She stated R15 s dialysis being three times a vare of the facility Leisure					
	used in the past. R15 activities, but did hav they have not incorpo program, since she w	lid not know this had been 5 received no 1:1 visits from e pastoral visits. TPD stated orated 1:1 into R15's vas the only person in the ies for all the residents but					
	needs to look into this	s for R15. She was unsure goals were or how this was					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY IPLETED
		00866	66 B. WING		12/01/2017	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,			2/01/2017
THE ESTA	TES AT TWIN RIVERS L	LC	MONT STREET MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21435	Continued From page	e 46	21435			
	staff about the chann R15's television so he TPD forgot to commu	stated she did not tell other els being programmed to e could watch sports. The inicate this to staff and was ot turning his TV station to				
	Although R15 was dependent upon staff, and was unable to physically participate in activities without staff assistance, the facility had not completed a comprehensive assessment of R15's activity needs or care plan interventions to meet those needs.					
	The director of activit develop, review, and procedures related to activities or designee appropriate actives a based on a comprehe director of activities d assessment could as have stimulation daily designee could then	o activities. The director of could assess residents for nd care plan for residents ensive assessment. The luring the comprehensive sure dependent residents y. The director of activities or				
	TIME PERIOD FOR (21) days.	CORRECTION: Twenty-one				
21695	MN Rule 4658.1415 Housekeeping, Opera		21695			1/10/18
	provide housekeepin necessary to maintai comfortable interior, i	oing. A nursing home must g and maintenance services n a clean, orderly, and including walls, floors, tures, equipment, lighting,				

STATE FORM

6899

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			B. WING			
	ROVIDER OR SUPPLIER	00866	DDRESS, CITY, STAT		12/01/2017	
		305 FRE				
THE ESTA	TES AT TWIN RIVERS L	LC ANOKA,	MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLET	
21695	Continued From page	e 47	21695			
	and furnishings.					
	This MN Requiremen	t is not met as evidenced				
	Based on observation review, the facility fail was kept clean, sanit	n, interview and document led to ensure the kitchen ary and in good repair which ffect all 43 residents who the kitchen.		corrected		
	Findings include:					
	9:15 a.m. with the Cu (CSM), a certified die facility registered diet	f the kitchen on 11/28/17, at Ilinary Services Manager Stary manager, and the Litian (RD)-A identified they In the kitchen, the following				
	washing sink had a a dust, debris and had splashed on the lid.	In located near the hand Id, that was covered in dirt, a dried gray substances The external can also had was dried on the outside of				
	metal cart that had a Decker blender along appliances on the car dust, crumbs and drie	ng sink was a four wheeled base of an Oster Black and g with other kitchen rt that were covered with ed debris. The three shelves e also covered with crumb,				
	a sticky residue that s in front of the refriger	ous debris, dirt, crumbs and stuck your shoes to the floor				

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00866	B. WING		12	2/01/2017
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
THE ESTA	TES AT TWIN RIVERS L	LC	MONT STREET MN 55303			
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21695	Continued From page	e 48	21695			
	refrigerator, carts, stoves, cook and prep area there was a heavy accumulation of visible crumbs, dirt and debris under all of these areas. There was a visible heavy build up of dirt and debris that was black in color located under the wheels and legs of the portable prep station, and refrigerator. There was a stainless steel three shelf chart, near the prep station with dried food, and debris splashed on the sides and lateral supports of the cart, along with dirt, crumbs and debris on the shelves of the cart. CSM stated they used this for transporting food items in and out of the kitchen.					
	of the dry storage are approximately 8 inch	d missing near the entryway ea. The area was es long by 4 inches long, and behind the baseboard.				
	storage area, that wa debris on each of the this was used for trar	hree shelf cart in the dry as full of dust, crumbs and ese shelves. CSM identified asporting food, and other or to residents in the facility.				
	residue on the outsid	a heavy white, cloudy le. There was a heavier build tance on the four corner vasher.				
		efrigerator had visible oris throughout the bottom of				
		d a various crumbs on the , that had not been cleaned.				
	The refrigerator/freez room, had shelves w	zer located in the serving				

STATE FORM

23SE11

If continuation sheet 49 of 52

STATEMENT	a Department of Heal	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		00966	00866 B. WING			10/04/0047	
	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE		14	2/01/2017	
		305 FRE		, 0002			
THE ESTA	TES AT TWIN RIVERS I	LLC ANOKA,	MN 55303				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE	
21695	Continued From pag	je 49	21695				
	debris and a sticky d had a heavy build of substances dried on individual resident ic Outside on the refrige brown, black colored edges of the refriger with the same substa refrigerator and freez During kitchen tour of following items were The window above th had visible dirt, debr had a heavy white bu sink, and around the Inside the two storag lids and plastic conta shelves had visible of had crumbs, debris a tracking making it dif sliding doors. There had a white build up handles had visible to baking oven there we the bottom. There we debris on the top and that could be scrape The dish room had 1 dishwashing area an tile corners were bro multiple large spider the length and width	Iried substance. The freezer various creamy color sticky the shelves. There were e cream cups in the freezer. gerator/freezer door there was d debris on the bottom and ator and freezer door, along ance under the handles of the zer.					
	tile. Under the dishw	asher was a heavy build up lor debris. Under the clean					
	dish racks located ne	ext to the wall had an area					

STATEMENT	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		00866	B. WING		12/01/2017	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	·	
THE ESTA	TES AT TWIN RIVERS L		MONT STREET			
		ANOKA,	MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T( DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
21695	Continued From page	e 50	21695			
	colored substance. T build up of a white vis between the dish roo 4x4 inch white tiles m linoleum piece in this baseboard and wall m Behind the linoleum w Across the wall in the splattered with a tan, approximately 8 feet against this wall were Review of the daily c thirteen plus areas fo wipe off all carts, clea stoves, ovens, wipe of The bottom of the for	area between the not attached to the wall. was a hole in the wall. e dish area the tiles were				
		shift cleaning schedules lovember 26, 2017 identified ning were left blank.				
	and CSM both stated needed some more v have been busy with also been working in	1/30/17 at 10:03 a.m. RD-A I they knew the kitchen vork, and cleaning. They staffing and the CSM has the kitchen as well. They sight, and we will make these				
	undated, identified ea in a clean, sanitary co Director is responsibl cleaning scheduled in employee is responsi	ch Cleaning schedule policy, ach facility will be maintained ondition. The Department le to provide and post the n their department. Each ible to know their assigned out during their work shift.				

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00866					
IAME OF P	ROVIDER OR SUPPLIER		B. WING 12/01/2 EET ADDRESS, CITY, STATE, ZIP CODE				
HE ESTA	ATES AT TWIN RIVERS L	LC	MONT STREET MN 55303				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO	LAN OF CORRECTION IVE ACTION SHOULD BE CO ED TO THE APPROPRIATE FICIENCY)		
21695	Each employee is res specified area for the Cleanliness will be m cleaning. SUGGESTED METH certified dietary mana develop, review, and procedures pertaining kitchen environment. manager or designee all dietary staff on the policies and procedu certified dietary mana conduct audits to ens completed.	sponsible to document in the ir completed duty. aaintained through regular IOD OF CORRECTION: The ager or designee could /or revise policies and g to a clean and sanitary	21695				