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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: BZ5R

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00866

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245298**

2.STATE VENDOR OR MEDICAID NO.
(L2) **400099400**

3. NAME AND ADDRESS OF FACILITY
(L3) **THE ESTATES AT TWIN RIVERS LLC**
(L4) **305 FREMONT STREET**
(L5) **ANOKA, MN** (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**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/26/2017** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **56** (L18)

13.Total Certified Beds (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With
Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program
Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:

___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
Bruce Melchert HFE NE II — 02/28//2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 03/17/2017 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
__X__ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
10/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30) **00**

VOLUNTARY
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS
Posted 03/20/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
February 10, 2017

Mr. Larry Passel, Administrator
Golden Livingcenter - Twin Rivers
305 Fremont Street
Anoka, MN 55303

RE: Project Number S5298028

Dear Mr. Passel:

On January 26, 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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:

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

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

Remedies - 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;

Potential Consequences - 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 & Certification
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (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 NO DATA, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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.

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 April 26, 2017 (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 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 July 26, 2017 (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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245298	A. BUILDING _____ B. WING _____	01/26/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT TWIN RIVERS LLC	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee,	F 225		3/7/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 02/16/2017

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F 225	Continued From page 1 which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 225		

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F 225	Continued From page 2 Based on interview and document review, the facility failed to ensure an allegation of abuse was immediately reported to the administrator and state agency for 1 of 3 resident (R4) allegations of abuse reviewed. Findings include: R4's quarterly Minimum Data Set (MDS) dated 10/21/16, indicated she was cognitively intact, and was very hard of hearing. The MDS also indicated R4 was able to express ideas and wants, and be understood, and also understood others, with clear comprehension. A review of a facility Verification of Investigation document dated 1/23/17, indicated "CNA [certified nursing assistant] answered call light and resident dropped some items on the floor as NAR [nursing assistance, registered] began to pick up items from the floor resident hit her over the head with her white communication board stating 'you are always yelling at me.'" The document identified the incident occurred on 1/21/17 in the resident's (R4) room, but no time was identified. During an interview on 1/24/17 at 2:49 p.m., R4 stated to the surveyor she felt she was verbally abused recently by an aide who was helping her in her room. R4 alleged that a nurse aide yelled at her and "asked me [R4]" why I was yelling at her (the nurse aide). R4 stated "that gal was nasty" when she talked to me, and added this nurse aide knows I am deaf or very hard of hearing. R4 stated she could not remember the exact date or time the incident occurred, but that it was evening, in the not-so-distant past. R4 was unable to identify the aide by name, but only that this staff person had been at the facility for a long	F 225	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This plan of Correction is submitted as the facility's credible allegation of compliance. F 225 It is the Policy of Golden Living Twin Rivers that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately to the administrator or designee of the facility and to other officials in accordance with Regulatory	

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F 225	Continued From page 3 time and still worked here. R4 also stated she reported this event, and was certain the staff know about it, because another nurse came into her room when it happened. R4 stated the incident was bordering on being undignified, but added "no one should be yelled at like she did." R4 also stated "I felt hurt by it. I think it was abuse." Review of nursing progress note dated 1/21/17 at 22:22 (10:22 p.m.) indicated "CNA [certified nursing assistant) answered call light and resident [R4] had dropped some items on the floor. As CNA was picking items up off of the floor resident hit her over the had with her white bored [sic] and stated 'you're always yelling at me.' CNA and resident were yelling at each other when the nurse arrived. Nurse asked the CNA to trade residents with another CNA and have them assume her care for the remainder of the shift." When interviewed on 1/26/17 at 10:57 a.m., the social worker (SW) stated she was aware of the incident involving R4 and knew there was a "VOI" (an interval, verification of information, investigation) of the event, but was not directly involved. The SW stated reading from the initial progress note, one wouldn't immediately question or think that (R4) was abused. The SW stated, however, if the aide was yelling at the resident, it should be a reportable event. The SW stated the purpose of the "VOI" was to follow up on an incident, make sure the resident was protected, identify if there was potential harm to a resident, and educate staff if needed. The SW stated typically abuse is reported first, to stage agency and administrator, then the facility investigation would be completed.	F 225	requirements through established policies and procedures (including to the State Survey and Certification Agency). Policy includes language reflecting changes to the new reporting guideline established in November 2016. New policy includes the following: suspected abuse shall be reported to the Administrator or designated representative and OHFC online reporting process not later than two hours after forming the suspicion of abuse, neglect, exploitation, or misappropriation of resident property. Resident # 4 was interviewed and states she feels safe in facility and has not expressed any further concerns with staff. She continues to state she feels safe in facility. Social Services will follow up with resident weekly and document follow up in medical record. The facility will continue to immediately investigate and report to the Sate Agency all alleged violations involving mistreatment, neglect, abuse, misappropriation of resident property, exploitation, and unknown injuries in accordance with regulatory requirements. A centralized incident tracking and reporting log will continue to be maintained to monitor timely reporting and completion of investigations. Facility staff will be re-educated on prevention of abuse, neglect, exploitation, and misappropriation of resident property. Training to include activities that constitute	

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F 225	Continued From page 4 During an interview on 1/26/17 at 1:23 p.m., licensed practical nurse (LPN)-A stated she was working on the day the incident happened, it was Saturday the 21st. LPN-A stated she had just come out of the medication room about 6:30 or 6:45 p.m., and heard NA-E and R4 "screeching" at each other in R4's room. LPN-A could not recall how long LPN-B and R4 were yelling, but there were several loud exchanges from both. LPN-A entered R4's room, and stated NA-E wrote on R4's white board (a communication board) "Why are you yelling at me?" LPN-A stated she did not think R4 read the message, but instead hit NA-E with the white board. LPN-A stated she told NA-E and R4 to settle down, then asked NA-E to have another nursing assistant to take care of R4 for the rest of the night. LPN-A stated she wanted to get NA-E away from R4 to not upset her anymore. LPN-A then stated she told LPN-B, the charge nurse, what happened, and LPN-B wrote a progress note about the incident. During the interview, LPN-A stated what NA-E did was "out of line" and was verbal abuse. LPN-A acknowledged she did not read the progress note, nor took any further action that day other than telling LPN-B about the incident. In an interview on 1/26/17 at 2:32 p.m. the director of nursing (DON) stated she learned of the incident on Monday (the 23rd) and had asked RN-A to "follow up." The DON stated the administrator also became aware of the incident on Monday, when we reviewed the progress notes. The DON stated we did not feel this was a reportable event, but added if (LPN-A) felt it was abuse at the time of the incident, she should have called the nurse on call, "and that would have started" the process to report.	F 225	abuse, neglect, exploitation and misappropriation of resident property Facility staff will be trained on immediately reporting to administrator or designee alleged violations involving abuse, neglect, exploitation, and misappropriation of resident property. Administrator, ADON, DON and Social Worker will be trained on reporting to OHFC online per regulatory reporting guideline Dietary, nursing, activities, social services, business office staff are being trained on dementia and prevention of abuse. Weekly audits of social services follow up with resident # 4 and all staff training. Tracking and reporting of alleged incidents will be completed as incidents occur. Administrator or designee will be responsible for monitoring compliance. The QAPI Committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted. Date of Compliance 3/7/17.	

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F 225	Continued From page 5 In an interview on 1/26/17 at 3:50 p.m., the executive director (ED) stated he became aware of the incident involving R4 on Monday, January 23rd., two days after the event occurred. The ED stated he needed to get more versed on the abuse reporting, but that we needed to investigate after we report. A facility document titled, Investigation and Reporting of Alleged Violations of Federal and State Laws Involving Mistreatment, Neglect, Abuse Injures of Unknown Source and Misappropriation of Resident's Property, effective 11/18/16, indicated it was the policy of the company to take appropriate steps "to prevent the occurrence of abuse.." The policy indicated it was the responsibility of each individual employee to immediately report "...all allegations of mistreatment, neglect, abuse....to the designated supervisor in charge." The policy defined abuse to include verbal abuse as "any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents....regardless of the age ability to comprehend..." The policy further directed abuse allegations be reported immediately to the executive director, and to also notify the state agency. Immediately was defined as, "as soon as possible," but not to exceed two (2) hours in the event of serious injury or death or twenty-four (24) hours for all other reports.	F 225		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that:	F 226		3/7/17

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	245298	A. BUILDING _____ B. WING _____	01/26/2017

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F 226	Continued From page 6 (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow its abuse prohibition policy to ensure all allegations of abuse were immediately reported to the administrator and State Agency for 1 of 3 resident (R4) allegations reviewed. Findings include:	F 226	F 226 It is the Policy of Golden Living Twin Rivers that the facility has policy and procedures that prohibit and prevent abuse, neglect, exploitation, mistreatment, including injuries of unknown origin, and misappropriation of resident property.	

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F 226	Continued From page 7 A facility document, titled Investigation and Reporting of Alleged Violations of Federal and State Laws Involving Mistreatment, Neglect, Abuse Injures of Unknown Source and Misappropriation of Resident's Property, effective 11/18/2016, indicated it was the policy of the company to take appropriate steps "to prevent the occurrence of abuse.." The policy indicated it was the responsibility of each individual employee to immediately report "...all allegations of mistreatment, neglect, abuse....to the designated supervisor in charge." The policy defined abuse to include verbal abuse as "any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents....regardless of the age ability to comprehend..." The policy further directed abuse allegations be reported immediately to the executive director, and to also notify the state agency. Immediately was defined as, "as soon as possible," but not to exceed two (2) hours in the event of serious injury or death or twenty-four (24) hours for all other reports. R4's quarterly Minimum Data Set (MDS), dated 10/21/16, indicated she was cognitively intact, and was very hard of hearing. The MDS also indicated R4 was able to express ideas and wants, and be understood, and also understood others, with clear comprehension. A review of a facility Verification of Investigation document, dated 1/23/17, indicated "CNA [certified nursing assistant] answered call light and resident dropped some items on the floor as NAR [nursing assistance, registered] began to pick up items from the floor resident hit her over the head with her white communication board stating 'you are always yelling at me.'" The	F 226	It is the Policy of Golden Living Twin Rivers that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately to the administrator or designee of the facility and to other officials in accordance with Regulatory requirements through established policies and procedures (including to the State Survey and Certification Agency). Policy includes language reflecting changes to the new reporting guideline established in November 2016. New policy includes the following: suspected abuse shall be reported to the Administrator or designated representative and OHFC online reporting process not later than two hours after forming the suspicion of abuse, neglect, exploitation, or misappropriation of resident property. Staff training on facility policy and procedure for prevention of abuse, neglect, exploitation, and the misappropriation of resident property and that every employee is a mandated reporter and that every employee MUST immediately report to administrator or designee alleged violations of abuse, neglect, exploitation, and misappropriation of resident property will be completed. All staff dementia training is being completed and includes abuse prevention. Administrator, ADON, DON, and social worker will be re-trained on reporting policy that includes suspected abuse must	

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F 226	Continued From page 8 document identified the incident occurred on 1/21/17 in the resident's (R4) room, but no time was identified. During an interview on 1/24/17 at 2:49 p.m., R4 stated to the surveyor she felt she was verbally abused recently by an aide who was helping her in her room. R4 alleged that a nurse aide yelled at her and "asked me [R4]" why I was yelling at her (the nurse aide). R4 stated "that gal was nasty" when she talked to me, and added this nurse aide knows I am deaf or very hard of hearing. R4 stated she could not remember the exact date or time the incident occurred, but that it was evening, in the not-so-distant past. R4 was unable to identify the aide by name, but only that this staff person had been at the facility for a long time and still worked here. R4 also stated she reported this event, and was certain the staff know about it, because another nurse came into her room when it happened. R4 stated the incident was bordering on being undignified, but added "no one should be yelled at like she did." R4 also stated "I felt hurt by it. I think it was abuse." Review of nursing progress note dated 1/21/17 at 22:22 (10:22 p.m.) indicated "CNA [certified nursing assistant] answered call light and resident [R4] had dropped some items on the floor. As CNA was picking items up off of the floor resident hit her over the had with her white bored [sic] and stated 'you're always yelling at me.' CNA and resident were yelling at each other when the nurse arrived. Nurse asked the CNA to trade residents with another CNA and have them assume her care for the remainder of the shift." When interviewed on 1/26/17 at 10:57 a.m., the	F 226	be reported within 2 hours of the alleged incident. Weekly audits of five staff following all staff training on preventing resident abuse and the role of a mandated reporter will be completed by social services director or designee. Tracking and reporting of alleged incidents will be completed as incidents occur. Administrator or designee will be responsible for monitoring compliance. The QAPI Committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted Date of completion 3/7/2017.	

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social worker (SW) stated she was aware of the incident involving R4 and knew there was a "VOI" (verification of information, an internal investigation) of the event, but was not directly involved. The SW stated the purpose of the "VOI" was to follow up on an incident, make sure the resident was protected, identify if there was potential harm to a resident, and educate staff if needed. The SW stated typically abuse is reported first, to stage agency and administrator, then the facility investigation would be completed.

During an interview on 1/26/17 at 1:23 p.m., licensed practical nurse (LPN)-A stated she was working on the day the incident happened, it was Saturday the 21st. LPN-A stated she had just come out of the medication room about 6:30 or 6:45 p.m., and heard NA-E and R4 "screeching" at each other in R4's room. LPN-A could not recall how long LPN-B and R4 were yelling, but that there were several loud exchanges from both. LPN-A entered R4's room, and stated NA-E wrote on R4's white board (a communication board) "Why are you yelling at me?" LPN-A stated she did not think R4 read the message, but instead hit NA-E with the white board. LPN-A stated she then told NA-E and R4 to settle down, then asked NA-E to have another nursing assistant to take care of R4 for the rest of the night. LPN-A stated she wanted to get NA-E away from R4 to not upset her anymore. LPN-A then stated she told LPN-B, the charge nurse, what had happened, and LPN-B wrote a progress note about the incident. During the interview, LPN-A stated what NA-E did was "out of line" and was verbal abuse. LPN-A acknowledged she did not read the progress note, nor took any further action that day other than telling LPN-B.

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F 226	Continued From page 10 In an interview on 1/26/17 at 2:32 p.m. the director of nursing (DON) stated she learned of the incident on Monday (the 23rd) and had asked RN-A to "follow up." The DON stated the administrator also became aware of the incident on Monday, when we reviewed the progress notes. The DON stated if [LPN-A] felt it was abuse at the time of the incident, she "should have called" the nurse on call, and that would have started the process to report. In an interview on 1/26/17 at 3:50 p.m., the executive director (ED) stated he became aware of the incident involving R4 on Monday, January 23rd. The ED indicated he needed personally to get more versed on the abuse reporting, but needed to investigate after we report, as the facility policy identifies.	F 226		
F 458 SS=B	483.90(e)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT (e)(1)(ii) Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide 80 square feet of floor space per resident in 8 of 28 resident rooms (room#s 4, 7, 17, 20, 21, 29, 35 and 36) which affected 14 residents (R8, R19, R32, R67, R20, R51, R41, R38, R35, R1, R82, R60, R65 and R69) who currently resided in these rooms. Findings include: During entrance conference on 1/23/2017, at 7:30 p.m. the facility executive director (ED) stated	F 458	F458 Golden Living Twin Rivers would like to request a waiver under F458 in regard to resident room size. The rooms to be included in this waiver are: 4, 7, 17, 20, 21, 29, 35, and 36. These rooms were constructed in 1962 and do not meet the current requirements for square footage in two-bed rooms. There is no method available to increase	3/7/17

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F 458	Continued From page 11 there were resident room size waivers in place for rooms 4, 7, 17, 20, 21, 29, 35 and 36, which did not meet the required minimum square footage. The following double resident rooms did not meet the required minimum square footage per resident: Room 4 = 150 square feet, or 75 square feet per resident, (R32) Room 7 = 152.5 square feet, or 76.25 square feet per resident, (R67) Room 17 = 150 square feet, or 75 square feet per resident, (R8 and R19) Room 20 = 150 square feet, or 75 square feet per resident, (R69 and R82) Room 21 = 150 square feet, or 75 square feet per resident, (R65 and R60) Room 29 = 150 square feet, or 75 square feet per resident, (R1 and R35) Room 35 = 150 square feet, or 75 square feet per resident, (R41 and R38) Room 36 = 155 square feet, or 77.5 square feet per resident, (R51 and R20) R32 resided in room 4, which was a double room stated on 1/24/17 at 8:30 p.m., he had no issues with the room, as there was only his bed in the room. R32 stated he felt the room had "ample space for my needs." R32's had double room and had furnishings consisting of: one bed, an over-the-bed table, C32's wheel chair (WC), and	F 458	the size of the rooms without causing hardship on the facility. Granting this waiver would not adversely affect the residents residing in the aforementioned rooms. The residents' health, treatments, comfort, safety, and wellbeing will be maintained at the highest possible level. Currently, there are no concerns or complaints from residents regarding the room size. The Director of Maintenance is responsible for the monitoring of this waivered requirement.	

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a small chest of drawers. R32's TV was mounted on the wall.

R67 resided in room 7 which was a double room stated on 1/24/17, at 9:57 a.m. that her room size was adequate and had no concerns with the room size. R67's room had furnishings on her side consisting of: one bed, a small chest of drawers and R67's WC. R67's TV was mounted on the wall. On the window side of the room stood a small chest of drawers and another bed.

R8 resided in room 17 which was a double room. She was unable to be interviewed due to cognitive impairment. During observation on 1/22/16 at 11:29 a.m. R8's room had furnishings on her side consisting of: one bed, a small chest of drawers and her WC. The hall side of the room 17 was shared with R19. R8 only slept in her room, spending the balance of the day by the nurses station or in group activities. Family could not be reached for comment about R8's room size.

R19, resided in room 17, which was a double room. Her quarterly Minimum Data Set (MDS) dated 12/16/16, indicated she was cognitively intact. When interviewed on 1/22/17 at 11:29 a.m., R19 stated she "was disappointed in the room size." She stated the area between the hall wall and the bed, "I have only a car spot for my wheel chair." R19 stated she had not told anyone about her concern, but felt the facility would not do anything about it. R19 stated she hoped to return to the assisted living facility where she lived previously. R19's double room and had furnishings on her side consisting of: one bed,

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R19's WC, a small chest of drawers, and an over-the-bed table where a radio and books were located. The window side of the room had a small chest of drawers and a bed, which was used by R8, as identified above.

During an interview on 1/26/17 at 8:10 a.m., nursing assistant (NA)- D, stated staff have no difficulty providing cares for R19, because she can stand and do a pivot transfer with assistance of one. NA-D stated R19 had never mentioned anything to her about the room size.

In an interview on 1/26/17 at 8:16 a.m., NA-B also stated there no concerns with room space while providing cares for R19.

On 1/26/17 at 8:27 a.m., the facility social worker (SW) stated she was unaware of (R19)'s complaint over the size of her room. The SW stated (R19) did not like having a roommate, and had been offered other resident rooms, including being next to a window, but (R19) had turned down all of these rooms.

R82, resided in room 20, stated during interview on 1/24/17, at 10:07 a.m. all he needed was a bed and a TV (television) and he did not have any problem with his room. R82 further stated the size of his room was just fine with him, adding, "I have no concerns about my room." R82 resided in a double room with furnishings including, a bed, bedside table, night stand, chest of drawers, and his wheelchair. R82 required the use use of a stand-up lift for transfers.

R69, resided in room 20, stated during interview on 1/24/17, at 2:22 p.m. he had no concerns with

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his room. R69 stated the size was just perfect and was happy with the accommodations and the size of his room. R69's room furnishings included, a bed, bedside table, night stand, chest of drawers, and his wheelchair.

During interview on 1/26/17, at 8:50 a.m. NA-F stated it was difficult to maneuver equipment when getting residents up in room 20, but was able to provide the necessary cares. NA-F stated, I am able to get my work done.

During interview on 1/26/17, at 9:09 a.m. NA-G stated it was difficult and challenging to get around with the lift in room 20, but it was "manageable." NA-G stated at times it was necessary to move furniture around and adjust things to make it work and complete resident cares.

R60, resided in room 21, stated during interview on 1/24/17, at 10:43 a.m., "My room is good." R60 stated he had a bed, dresser, night stand, and a window. He added he had no concerns with the size of his room and he could get around good. R60 added, "I am used to an apartment and this is not much different." R60 resided in a double room with furnishings that included, a bed, bedside table, night stand, chest of drawers, and his wheelchair.

R65, resided in room 21, stated during interview on 1/24/17, at 9:04 a.m., "My room is just fine." R65 added he had no trouble getting around in his room and the size was just fine with him. R65 resided in a double room with furnishings including, a bed, bedside table, night stand, chest of drawers, and his wheelchair.

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During interview on 1/26/17, at 8:50 a.m. NA-F stated that she had no concerns with the size of room 21. NA-F stated staff were able to assist both R60 and R65 in room 21 with the cares as needed and was not affected by the size of the room.

During interview on 1/26/17, at 9:07 a.m. NA-G stated, he was able to complete my work in Room 21 "without any difficulty."

R1, resided in room 29, stated during interview on 1/24/17, at 8:37 a.m. he had no concerns with room size, his ability to get around in the space provided. The room worked well. R1's bed was positioned on the wall farthest from the door, against the window. R1's recliner was against the wall, at the head of the bed. His television was placed on a nightstand which is positioned between resident's closet. R1 ambulates with the use of a rolling walker and stated was able to get around room without difficulty.

R35, resided in room 29, stated during interview on 1/24/17, at 8:39 a.m. the room "could be bigger" but he was able to get around room. He would like to have his recliner in the room, but the space does not allow for that. R35 stated he preferred to stay in this room as he was content with current roommate and placement of room. R35's nightstand was located on the wall to the right of the door upon entering the room, with a television on the nightstand. R35's bed was positioned on the wall under the light, with the nightstand at the foot of the bed. His overbed table was near the divider curtain at the head of his bed. R35 was dependent on a wheelchair for mobility.

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R51, resided in room 36, stated on 1/23/17, at 6:51 p.m. they had no concerns regarding room size and ability to reside in current room. R51 indicated there were no problems with receiving cares related to limited space. R51's nightstand is located inside the doorway and bed was positioned under the light on the side wall. R51 has her television on the nightstand, next to the foot of the bed. R51 used a standing lift for transfers and is dependent on a wheelchair for mobility.

R20, resided in room 36, stated during interview on 1/23/17, at 6:51 p.m. they had no concerns with current room size and indicated that they were able to use adaptive equipment without any concerns in current space. R20's bed was positioned on the opposite wall from the door and was positioned under the window. R20's recliner was positioned at the head of his bed, against the wall. R20's night stand was at the foot of the bed in front of the closet doors, allowing a narrow space to open the door. R20's television was on the dresser located between the closet doors. R20 used a wheeled walker and the room arrangement allowed for a clear path to the bathroom, as well as an enter/exit to the doorway.

R38, who resided in room 35, stated during interview on 1/23/17, at 6:45 p.m. the room size was not of concern as "I don't need a lot of stuff." R38's bed was positioned on the wall opposite of the doorway under the window. R35's night stand was located at the head of her bed with an overbed table beside the bed. R38's television was on a shelf near the closet. R38 was dependent on a wheelchair for mobility and was dependent on transfers with a mechanical lift.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT TWIN RIVERS LLC	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 458	Continued From page 17	F 458		

R41, who resided in room 35, was unable to be interviewed on 1/24/17, at 2:11 p.m. related to cognitive impairment. R41's room was arranged with the nightstand positioned directly inside the door, with the bed positioned on the wall next to the nightstand. R41's overbed table was against the wall near the bathroom door and closets. R41 uses a wheelchair for mobility.

During interview on 1/23/17 at 6:56 p.m. nursing assistant (NA)-C stated there had been no problems or concerns of assisting residents with mobility in rooms 29, 35, and 36 related to decreased room size. NA-C reported no concerns with providing assistance with personal cares.

During interview on 1/24/17, at 2:20 p.m. NA-A stated that there are no problems with care delivery to residents residing in rooms 29, 35, and 36. NA-A stated that staff are aware of where to place the chairs, lifts and assistive devices to work most effectively. NA-A stated that there are no cares that they have been unable to perform.

During interview on 1/25/17 at 11:23 a.m. with NA-B stated there have been no problems with provision of care related to space available in the rooms 29, 35 and 36.

During interview on 1/26/17 11:15 a.m., the executive director (ED) stated he was aware the facility had rooms that did not offer 80 sq ft per resident. The ED further stated, should a resident and/or staff voice concerns about residing in or being unable to provide care in one of these rooms. The facility would have the responsibility to make other arrangements to meet residents' needs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245298	A. BUILDING _____ B. WING _____	01/26/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT TWIN RIVERS LLC	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245298	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/24/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - TWIN RIVERS	**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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on January 24, 2017. At the time of this survey, Golden Livingcenter Twin Rivers was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. This 1-story building was constructed in 1962 and was determined to be of Type II (111) construction. With an addition of the same type in 1977. It has a partial basement and is automatic sprinkler protected throughout. The facility has fire alarm detection in corridors and spaces open to the corridor that is monitored for fire department notification. The facility has a capacity of 56 and had a census of 44 at the time of the inspection. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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