Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 21, 2023

Administrator
The Estates At Twin Rivers LLC
305 Fremont Street
Anoka, MN 55303

RE: CCN: 245298
Cycle Start Date: April 13, 2023

Dear Administrator:

On May 9, 2023, we notified you a remedy was imposed. On May 31, 2023 and June 2, 2023, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of May 30, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective July 13, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of May 9, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 13, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on May 30, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 21, 2023

Administrator
The Estates At Twin Rivers LLC
305 Fremont Street
Anoka, MN 55303

Re: Reinspection Results
Event ID: M30412

Dear Administrator:

On May 31, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 13, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 1, 2023

Administrator
The Estates at Twin Rivers, LLC
305 Fremont Street
Anoka, MN 55303

RE: CCN: 245298
Cycle Start Date: April 13, 2023

Dear Administrator:

On April 13, 2023, a 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

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

The state agency may, in lieu of an onsite 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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Karen Aldinger, Unit Supervisor
St. Cloud A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by July 13, 2023 (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).

In addition, if substantial compliance with the regulations is not verified by October 13, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 1, 2023

Administrator
The Estates at Twin Rivers, LLC
305 Fremont Street
Anoka, MN 55303

Re: State Nursing Home Licensing Orders
Event ID: M30411

Dear Administrator:

The above facility was surveyed on April 11, 2023 through April 13, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Karen Aldinger, Unit Supervisor
St. Cloud A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

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

Please feel free to call me with any questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	245298	A. BUILDING: _____ B. WING _____	4/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT TWIN RIVERS LLC	305 FREMONT STREET ANOKA, MN

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 582	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility lacked evidence the facility provided the Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN; CMS-10055) and the Notice of Medicare Non-Coverage (CMS-10123) to 2 of 3 residents (R90 and R11) reviewed whose Medicare Part A coverage ended and then remained in the facility. Findings include: R90's (Albert May) Medicare A coverage documentation, provided by the facility, the records lacked evidence R90 nor his family were provided the Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN; CMS-10055) and the Notice of Medicare Non-Coverage (CMS-10123) when R90's Medicare A Skilled Care ended.

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245298	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 4/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT TWIN RIVERS LLC	**305 FREMONT STREET ANOKA, MN**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 582	Continued From Page 1

In review of the survey worksheet provided to the facility (SNF Beneficiary Protection Notification Review CMS-20052) indicated R90 began his Medicare A stay on 2/10/23, and was discharged from coverage on 3/01/23, and discharge home on 2/28/23.

R11's Medicare A coverage documentation, provided by the facility, the records lacked evidence R11 nor his family were provided the Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN; CMS-10055) and the Notice of Medicare Non-Coverage (CMS-10123) when R11's Medicare A Skilled Care ended.

In review of the survey worksheet provided to the facility (SNF Beneficiary Protection Notification Review CMS-20052) indicated R began his Medicare A stay on 11/23/22, and was discharged from coverage on 11/29/22. R11 remained in the facility.

In an interview on 4/12/23, at 1:41 p.m. the administrator (ADM) stated that the facility was unable to locate evidence that the Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN; CMS-10055) and the Notice of Medicare Non-Coverage (CMS-10123) were provided to either the resident or family. ADM stated during R90's stay, the office manager was out with COVID, and R11's notices were over looked.

In review of the facility's policy, entitled: ABN/NOMNC Policy and Procedure (effective 2/20/23) indicted the following:

1. Business Office Manager:
   a. Primary person responsible for completing NOMNC/ABN

2. Social Worker:
   a. Must complete the NOMNC/ABN in the event the business office manager is unavailable.

3. MDS:
   a. Must complete the NOMNC/ABN in the event the business office manager and social worker are both absent.

4. Administrator:
   a. Must ensure that this process is followed and coordinated between the three key departments so that no forms are missed or incomplete. If all three departments are vacant; you must designate and individual on the facility team to fulfill this key function.

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 _____	C 04/13/2023

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
E 000	Initial Comments On April 11, 2023 through April 13, 2023, a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
F 000	INITIAL COMMENTS On April 11, 2023 through April 13, 2023, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaints were reviewed The following complaints were reviewed with no deficiency issued. H52981054C (MN00083151) H52981053C (MN00083169) H52981052C (MN00083282) H52981051C (MN00083407)	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/10/2023

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.

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 _____	C 04/13/2023

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	Continued From page 1 H52981050C (MN00083734) H52981049C (MN00090526) H52981084C (MN00092033) H52981107C (MN00091756) H52981105C (MN00091430) H52981106C (MN00090836) H52981108C (MN00090797) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on document review, observations, and resident and staff interviews, the facility failed to ensure 2 of 6 residents (R18 and R137) reviewed for Activities of Daily Living (ADLs) received grooming services consistently per their plan of care. R18 and R137 were not bathed per their plans of care. Findings include:	F 677	R18 was offered and provided assistance with bathing. R18's plan of care and nursing assistant sheet has been reviewed and revised as necessary. Refusals of care and/or preference changes related to bathing for R18 will be documented per policy. R137 was offered and provided assistance with bathing. R137's plan of	5/30/23

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 _____	C 04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 677	Continued From page 2 R18's Admission Record, indicated the resident was admitted on 03/23/23 with diagnoses including acute and chronic respiratory failure and end stage renal disease. R18's admission Minimum Data Set (MDS) dated 3/29/23, identified, mild cognitive impairment, and had not been bathed during the assessment period. R18's undated Activities of Daily Living (ADL) care plan indicated the resident had a self-care deficit related to her diagnosis of end stage renal disease and respiratory failure. Interventions included, "Assist with bathing." The facilities undated Shower Schedule was reviewed and indicated all showers were scheduled by room number, one time weekly, rather than by resident preference. The schedule indicated R18's showers were to be given on Tuesdays. R18's Shower Records, dated 3/23/23 through 4/13/23, indicated R18 had not been bathed since her admission to the facility. No refusals were documented in the resident's record. R18 was observed seated in her wheelchair in her room on 4/11/23 at, 11:16 a.m. and 3:42 p.m. on 4/11/23 at 3:50 p.m., and on 4/12/23, at 11:13 a.m. and 5:45 p.m. The resident appeared disheveled during all of the observations. When interviewed on 4/11/23, at 3:50 p.m. R18 stated, "I have had not had a shower since I've been here. I need a shower. I have been using the wipes to clean myself up." R18's family	F 677	care and nursing assistant sheet has been reviewed and revised as necessary. Refusals of care and/or preference changes related to bathing for R137 will be documented per policy. All residents who reside in the facility have the potential to be affected. Residents were interviewed to ensure bathing preferences are being met. Residents will continue to be assessed for these specific preferences and needs upon admit/re-admit, care conferences, and as needed with individual request. The policy and procedure for Activities of Daily Living (ADLs) was reviewed and remains current. Education has been initiated for nursing staff and IDT regarding patient preferences. If a resident refuses showers or cares the nurse is to be notified and proper documentation completed. Audits of 3 residents will be completed weekly for 4 weeks, monthly for 2 months, and then QAPI will review audit findings and make necessary recommendations specific to bathing. The Director of Nursing/designee is responsible for ensuring compliance.	

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 _____	C 04/13/2023

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 677	Continued From page 3 member, who was in the room visiting the resident at the time of the interview, stated she visited the resident in the facility almost daily, confirmed the resident had not been bathed since admission R18 stated, "They said one bath a week and one bedding change a week and that's it." During a follow-up interview with R18 on 04/12/23 at 5:45 p.m., she stated she normally took a shower every night at home, and this was her preference related to bathing in the facility, as well. She stated she had not been asked about her bathing preferences since she had been admitted to the facility. R137's Admission Record, indicated the resident was admitted on 3/29/23 with diagnoses including alcoholic cirrhosis of the liver and liver failure. R137's admission MDS dated 4/4/23, identified cognitively intact and required extensive assistance for bathing. R137's undated Activities of Daily Living (ADL) care plan, indicated the resident had a self-care deficit related to his diagnosis of cirrhosis of the liver. Interventions included, "Assist with bathing." The facilities undated Shower Schedule was reviewed and indicated all showers were scheduled by room number, one time weekly, rather than by resident preference. The schedule indicated R137's showers were to be given on Fridays. R137's Shower Records, dated 3/29/23 through 4/13/23, indicated R137 was bathed one time during that period, on 3/30/23. No refusals were	F 677		

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 _____	C 04/13/2023

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 677	Continued From page 4 documented in the resident's record. R137 was observed seated in his wheelchair in his room on 4/11/23 at 12:35 p.m., on 4/12/23 at 10:13 a.m., 11:07 a.m. and 2:34 p.m., and 4:28 p.m. The resident was disheveled, and his hair was uncombed during all of the observations. During an interview with R137, and his family member on 4/11/23 at 12:35 p.m., both stated the resident had not had a shower since he was admitted to the facility on 3/29/30. The resident stated he had been in the hospital for 13 days before being admitted to the facility, and had not been given a shower there, either. The resident's wife confirmed R137 had been given a sponge bath on 03/30/23, and stated, "He needs a shower." During a follow-up interview with R137 on 4/12/23 at 4:28 p.m., he stated he thought he had been given a sponge bath on the second or third day after he was admitted to the facility, but had not had a shower or a bath since. R137 said his preference was to receive a bath every three days. During an interview with nursing assistant (NA)-A on 4/12/23 at 4:55 p.m., she indicated she was familiar with R18 and had been working at the facility for about six weeks, and stated residents received showers once per week based on the shower schedule located at the nurse's station. NA-A confirmed showers were given based on room number rather than resident preference. She stated all showers were documented in the NA documentation in the facility's electronic medical record (EMR). NA-A stated she had never given R18 or R137 a shower.	F 677		

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	245298	A. BUILDING _____ B. WING _____	C 04/13/2023

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F 677	Continued From page 5 During an interview with NA-B on 4/12/23 at 5:18 p.m., he stated he had never given R18 or R137 a shower, and confirmed showers were given based on room number rather than resident preference. NA-B also confirmed showers were documented in the NA documentation in the facility's EMR. He stated If someone refused a shower, "R" for refused was to be documented on the resident's shower record, and the nurse was to be notified so he or she could write a progress note about the refusal. During an interview with the director of nursing (DON) on 4/13/23 at 9:01 a.m., she confirmed showers were generally done once per week, based on each resident's room number. She stated her expectation was that showers were to be done based on resident preference. She stated, "Showers have been an issue with agency staffing, and (staff) not getting them done." The facility's "Activities of Daily Living (ADLs)/Maintain Abilities Policy" dated 03/31/23 read, in pertinent part, "Based on the comprehensive assessment of the resident and consistent with the resident's needs and choices, the facility will provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable;" and "The facility will provide care and services for the following activities of daily living: a. Hygiene - bathing, dressing, grooming and oral care."	F 677		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)	F 690		5/30/23

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F 690	Continued From page 6 §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on document review, observations, and staff and resident interviews, the facility failed to	F 690	R137's catheter was removed on 04/14/2023 per physician order. R137's	

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F 690	Continued From page 7 ensure a urinary catheter in use for 1 of 1 residents (R137) reviewed for use of a urinary catheter was necessary. The resident's catheter was not removed per physician's order. Findings include: R137's Admission Record, indicated the resident was admitted on 3/29/23 with diagnoses including alcoholic cirrhosis of the liver and liver failure. R137's admission Minimum Data Set (MDS) dated 4/4/23, identified cognitively intact, and had an indwelling urinary catheter. R137's undated Catheter Care Plan, indicated the resident had altered elimination related to cirrhosis. The care plan indicated the resident had a urinary catheter in place. Interventions included, "Monitor foley catheter output," and "Change Foley catheter per policy," and "Foley catheter care per policy." R137's Hospital Discharge Orders dated 3/29/23, included, "Remove Foley in 5 days. Up to void with post void residual check by bladder ultrasound each shift for 24 hours and as needed for voiding difficulties. Straight catheterize if post void residual [greater than] 300 cc [cubic centimeters]. Call MD [Medical Doctor] if patient straight catheterized twice." R137's Order Summary Report, dated 4/13/23, revealed no orders for the resident's urinary catheter or associated catheter care. The report also did not reveal orders for the removal of R137's catheter with associated monitoring of post void residual.	F 690	plan of care has been reviewed and revised as necessary. All residents with a urinary catheter have the potential to be affected. Residents with urinary catheters were reviewed to ensure appropriate diagnosis. The policy and procedure for urinary continence and incontinence was reviewed and remains current. Education has been initiated with licensed nursing staff on ensuring patients who admit with urinary catheters are assessed for removal as soon as possible unless they have appropriate clinical condition that demonstrates necessity. IDT will review in daily clinical meeting. Audits of 3 residents will be completed weekly for 4 weeks, monthly for 2 months, and then QAPI will review the audit findings and make recommendations specific to urinary catheter use. The Director of Nursing/designee is responsible for ensuring compliance.	

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F 690	Continued From page 8 R137's comprehensive record was reviewed, and no assessment related to the resident's use of the urinary catheter could be found. R137's Provider Encounter Note, dated 4/4/23, included, "Remove Foley catheter. Check post-void residuals each shift x [times] 48 hours and as needed for voiding difficulties. Straight cath [catheter] if Post-Void Residual is >300 cc. Replace foley catheter if straight cath [catheter] is needed for third time." R137's Provider Encounter Note, dated 4/6/23, included, "Foley catheter is in place, no documentation as to whether or not it was removed and replaced versus never removed. Urine is dark orange/brown presumably from bilirubin staining. Plan: 1. Remove Foley catheter with PVRs [post void residual checks] x 48 hrs. [hours]." R137's Medication Administration Records (MARS) and Treatment Administration Records (TARS) identified, the resident's catheter was still in place in his bladder as of 4/13/23. The records indicated no attempted removal of the catheter or post void residual trial for the resident. R137's Provider Encounter Note, dated 4/10/23, included, "Re-ordered catheter removal. Family reports they beilieve (sic) (R137) has been refusing the catheter removal. Per discssion (sic) with (R137), he understands the risks and benefits, and says he is agreeable to catheter removal now." R137 was observed in his room on 4/11/23 at 10:59 a.m. and 11:34 a.m., and on 4/12/23 at 10:15 a.m. 2:35 p.m., 3:34 p.m., and 4:30 p.m..	F 690		

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F 690	Continued From page 9 The resident had a urinary catheter in place in his bladder during all the observations. R137 was interviewed on 4/11/23 at 10:59 a.m. he indicated his urinary catheter had been placed at the hospital. He stated an attempt was made to remove the catheter at the hospital, but he was unable to void at that time and so the catheter had been replaced. He stated no attempts to remove the catheter had been made since he had been admitted to the facility on 3/29/23. He had not been approached about it's removal. During a follow-up interview with R137 on 4/12/23 at 4:30 p.m., he indicated staff had replaced his catheter bag the previous Monday (4/12/23) due to it was leaking but no attempts had been made to remove the catheter that week. He stated, "I guess they are just going to leave it in." During an interview with registered nurse (RN)-A and RN-B on 4/12/23 at 3:34 p.m., they both indicated R137 had initially refused to have his catheter removed and stated they hadn't heard anything about removing the resident's catheter since. RN-A stated she was not aware of any current order to remove the resident's catheter. During an interview with the director of nursing (DON) on 4/13/23 at 9:12 a.m., she stated, "I thought it (R137's urinary catheter) was removed." The DON confirmed the order to remove the resident's catheter had not been entered into the resident's electronic medical record and stated, "I will check on it. The catheter should have been taken out." The facility's policy related to urinary catheter use was requested on 4/13/23 at approximately 9:00	F 690		

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F 690	Continued From page 10 a.m. During an interview with the DON on 4/13/23 at 1:35 p.m., she stated the facility did not have a policy addressing the use of urinary catheters.	F 690		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on document review, observations and staff interviews, the facility failed to ensure a medication error rate of less than 5%. Three errors were made with a total of 25 opportunities for error, resulting in a 12.0% error rate. The errors involved one resident (R87), who was not given two medications because they were not available in the facility and whose lidocaine patch was not removed per physician's order. Findings include: R87's Admission Record, dated 4/13/23, indicated the resident was admitted to the facility on 4/6/23 with diagnoses including hypertension, displaced fracture of right tibia, multiple fractures of ribs, and edema. R87's Order Summary Report, dated 4/13/23, indicated orders for torsemide (a diuretic medication used to decrease fluid overload) 10 milligrams (MG) twice daily, Aspirin 81 MG Enteric Coated once daily, and Lidocaine patch (a patch used for pain control) 4% on for 12 hours and off for 12 hours to upper back.	F 759	R87 was discharged from the facility on 04/24/2023. All residents who reside in the facility have the potential to be affected. A full-house audit has been initiated to ensure all physician ordered medications are available to all residents. The policy and procedure Medication Administration was reviewed and remains current. Education has been initiated and remains ongoing with licensed nursing staff to ensure medication is correctly administered in compliance with physician orders. Audits of 3 residents will be completed weekly for 4 weeks, monthly for 2 months, and then QAPI will review audit findings and make necessary recommendations specific to medication administration. The Director of Nursing/designee is responsible for ensuring compliance.	5/30/23

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F 759	Continued From page 11 Registered nurse (RN)-A was observed administering R87's medication on 2/12/23 at 9:16 a.m. RN-A was unable to locate aspirin 81 MG in the facility and was unable to administer the medication. The nurse was able to locate torsemide 20 MG tablets but was unable to locate 10 MG tablets and was unable to administer the medication. When RN-A applied the resident's lidocaine patch, the resident's patch from the previous day was still on R87's upper back (even though it was ordered to be removed the prior evening). During an interview with RN-A on 4/12/23 at 9:45 a.m., she indicated she was not able to cut the torsemide tablet in half and so would need to order the correct dosage from the pharmacy. She stated she was unable to locate enteric coated aspirin 81 MG tablets and would have to order this medication from the pharmacy, as well. She stated the medications were expected to be available in the facility by later that evening or the next morning. In addition, RN-A stated the resident's lidocaine patch applied the previous day should have been removed the evening prior per physician's orders. During an interview with the director of nursing (DON) on 4/13/23 at 9:21 a.m., she confirmed the torsemide and aspirin enteric coated should have been available in the facility for administration to R87. She stated physician's orders should have been followed for the removal of the resident's lidocaine patch.	F 759		
F 912 SS=E	Bedrooms Measure at Least 80 Sq Ft/Resident CFR(s): 483.90(e)(1)(ii)	F 912		5/30/23

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F 912	Continued From page 12 §483.90(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 39 resident rooms (room#s 4, 7, 17, 20, 21, 29, 35 and 36) which affected 9 current residents (R9, R16, R140, R141, R29, R26, R17, R11, R22 and R28) who currently resided in these rooms. Findings include: During the entrance conference on 4/11/23, at 10:53 a.m. the facility administrator stated there had been no changes in resident room sizes, and there were waivers in place for room numbers: 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 (currently a conference room) Room 7 = 152.5 square feet, or 76.25 square feet per resident, (R9, R16) Room 17 = 150 square feet, or 75 square feet per resident, (R140, R141) Room 20 = 150 square feet, or 75 square feet per resident, (R29, R26) Room 21 = 150 square feet, or 75 square feet per	F 912	Facility received waiver for identified rooms. Residents who reside in rooms 7, 17, 20, 21, 29, 35, 36 have the potential to be affected. The policy and procedure regarding bedroom size was reviewed and remains current.	

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F 912	Continued From page 13 resident, (R17) Room 29 = 150 square feet, or 75 square feet per resident, (R11) Room 35 = 150 square feet, or 75 square feet per resident, (R22) Room 36 = 155 square feet, or 77.5 square feet per resident, (R28) On 4/12/23, at 9:30 a.m. R29 (room 20) stated he had no concerns regarding the size of the room. On 4/12/23, at 9:40 a.m. R28 (room 36) stated she had no concerns regarding the size of the room. R28 stated she likes the extra space and used the extra bed for things On 4/12/23, at 10:17 a.m. R140 (room 17) stated she had no concerns regarding room size. On 4/12/23, at 10:17 a.m. R141 (room 17) stated no concerns with the her room. On 4/12/23, at 10:00 a.m. R26 (room 20) stated he had no concerns regarding the size of the room. On 4/12/23, at 1:00 p.m. R22 (room 35) stated she had no concerns regarding the size of the room. R22 stated she uses the extra bed for, "my stuff." On 4/12/23, at 1:05 p.m. R17 (room 21) stated he had no concerns regarding the size of the room. On 4/12/23, at 4:40 p.m. R16 (room 7) stated he spends most of his time out with the other	F 912		

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F 912	Continued From page 14 residents, and normally only in the room to sleep On 4/13/23, at 9:30 a.m. R11 (room 29) stated he had no concerns regarding the size of the room. On 4/13/23, at 10:30 a.m. R9 (room 7). who was just back from the hospital stated he had no concerns with the room size, while he is there only to to nap or sleep at night. 4/12/2023, at 1:00 p.m. nursing assistant (NA-A) stated the rooms are tight in the rooms that have two residents in them, but the residents currently in them are not lifts and are able to self transfer into their own wheel chair or walk like R26. 4/12/2023, at 9:40 a.m. registered nurse (RN-B) stated that the room sizes in the smaller double rooms currently work ok. There is not a lot of medical equipment for any of them and all residents are able to get out on their own, with the exception of R11 who is dependent on staff for transfers. However he is in the room alone.	F 912		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On April 11, 2023 through April 13, 2023, a State Licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you	2 000		

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2 000	Continued From page 1 have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed with no deficiency issued. H52981054C (MN00083151) H52981053C (MN00083169) H52981052C (MN00083282) H52981051C (MN00083407) H52981050C (MN00083734) H52981049C (MN00090526) H52981084C (MN00092033) H52981107C (MN00091756) H52981105C (MN00091430) H52981106C (MN00090836) H52981108C (MN00090797) Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing	2 000		

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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) COMPLETE DATE
2 000	Continued From page 2 orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	2 910		5/30/23

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2 910	Continued From page 3 This MN Requirement is not met as evidenced by: Based on document review, observations, and staff and resident interviews, the facility failed to ensure a urinary catheter in use for 1 of 1 residents (R137) reviewed for use of a urinary catheter was necessary. The resident's catheter was not removed per physician's order. Findings include: R137's Admission Record, indicated the resident was admitted on 3/29/23 with diagnoses including alcoholic cirrhosis of the liver and liver failure. R137's admission Minimum Data Set (MDS) dated 4/4/23, identified cognitively intact, and had an indwelling urinary catheter. R137's undated Catheter Care Plan, indicated the resident had altered elimination related to cirrhosis. The care plan indicated the resident had a urinary catheter in place. Interventions included, "Monitor foley catheter output," and "Change Foley catheter per policy," and "Foley catheter care per policy." R137's Hospital Discharge Orders dated 3/29/23, included, "Remove Foley in 5 days. Up to void with post void residual check by bladder ultrasound each shift for 24 hours and as needed for voiding difficulties. Straight catheterize if post void residual [greater than] 300 cc [cubic centimeters]. Call MD [Medical Doctor] if patient straight catheterized twice." R137's Order Summary Report, dated 4/13/23, revealed no orders for the resident's urinary	2 910	Corrected.	

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2 910	Continued From page 4 catheter or associated catheter care. The report also did not reveal orders for the removal of R137's catheter with associated monitoring of post void residual. R137's comprehensive record was reviewed, and no assessment related to the resident's use of the urinary catheter could be found. R137's Provider Encounter Note, dated 4/4/23, included, "Remove Foley catheter. Check post-void residuals each shift x [times] 48 hours and as needed for voiding difficulties. Straight cath [catheter] if Post-Void Residual is >300 cc. Replace foley catheter if straight cath [catheter] is needed for third time." R137's Provider Encounter Note, dated 4/6/23, included, "Foley catheter is in place, no documentation as to whether or not it was removed and replaced versus never removed. Urine is dark orange/brown presumably from bilirubin staining. Plan: 1. Remove Foley catheter with PVRs [post void residual checks] x 48 hrs. [hours]." R137's Medication Administration Records (MARS) and Treatment Administration Records (TARS) identified, the resident's catheter was still in place in his bladder as of 4/13/23. The records indicated no attempted removal of the catheter or post void residual trial for the resident. R137's Provider Encounter Note, dated 4/10/23, included, "Re-ordered catheter removal. Family reports they beilieve (sic) (R137) has been refusing the catheter removal. Per discssion (sic) with (R137), he understands the risks and benefits, and says he is agreeable to catheter removal now."	2 910		

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2 910	Continued From page 5 R137 was observed in his room on 4/11/23 at 10:59 a.m. and 11:34 a.m., and on 4/12/23 at 10:15 a.m. 2:35 p.m., 3:34 p.m., and 4:30 p.m.. The resident had a urinary catheter in place in his bladder during all the observations. R137 was interviewed on 4/11/23 at 10:59 a.m. he indicated his urinary catheter had been placed at the hospital. He stated an attempt was made to remove the catheter at the hospital, but he was unable to void at that time and so the catheter had been replaced. He stated no attempts to remove the catheter had been made since he had been admitted to the facility on 3/29/23. He had not been approached about it's removal. During a follow-up interview with R137 on 4/12/23 at 4:30 p.m., he indicated staff had replaced his catheter bag the previous Monday (4/12/23) due to it was leaking but no attempts had been made to remove the catheter that week. He stated, "I guess they are just going to leave it in." During an interview with registered nurse (RN)-A and RN-B on 4/12/23 at 3:34 p.m., they both indicated R137 had initially refused to have his catheter removed and stated they hadn't heard anything about removing the resident's catheter since. RN-A stated she was not aware of any current order to remove the resident's catheter. During an interview with the director of nursing (DON) on 4/13/23 at 9:12 a.m., she stated, "I thought it (R137's urinary catheter) was removed." The DON confirmed the order to remove the resident's catheter had not been entered into the resident's electronic medical record and stated, "I will check on it. The catheter should have been taken out."	2 910		

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2 910	Continued From page 6 The facility's policy related to urinary catheter use was requested on 4/13/23 at approximately 9:00 a.m. During an interview with the DON on 4/13/23 at 1:35 p.m., she stated the facility did not have a policy addressing the use of urinary catheters. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and revise urinary catheter policies as well as physician order policies, educate staff, audit for compliance and bring to QA for continued monitoring. . TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 910		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually	21545		5/30/23

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21545	Continued From page 7 requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on document review, observations and staff interviews, the facility failed to ensure a medication error rate of less than 5%. Three errors were made with a total of 25 opportunities for error, resulting in a 12.0% error rate. The errors involved one resident (R87), who was not given two medications because they were not available in the facility and whose lidocaine patch was not removed per physician's order. Findings include: R87's Admission Record, dated 4/13/23,	21545	Corrected.	

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21545	Continued From page 8 indicated the resident was admitted to the facility on 4/6/23 with diagnoses including hypertension, displaced fracture of right tibia, multiple fractures of ribs, and edema. R87's Order Summary Report, dated 4/13/23, indicated orders for torsemide (a diuretic medication used to decrease fluid overload) 10 milligrams (MG) twice daily, Aspirin 81 MG Enteric Coated once daily, and Lidocaine patch (a patch used for pain control) 4% on for 12 hours and off for 12 hours to upper back. Registered nurse (RN)-A was observed administering R87's medication on 2/12/23 at 9:16 a.m. RN-A was unable to locate aspirin 81 MG in the facility and was unable to administer the medication. The nurse was able to locate torsemide 20 MG tablets but was unable to locate 10 MG tablets and was unable to administer the medication. When RN-A applied the resident's lidocaine patch, the resident's patch from the previous day was still on R87's upper back (even though it was ordered to be removed the prior evening). During an interview with RN-A on 4/12/23 at 9:45 a.m., she indicated she was not able to cut the torsemide tablet in half and so would need to order the correct dosage from the pharmacy. She stated she was unable to locate enteric coated aspirin 81 MG tablets and would have to order this medication from the pharmacy, as well. She stated the medications were expected to be available in the facility by later that evening or the next morning. In addition, RN-A stated the resident's lidocaine patch applied the previous day should have been removed the evening prior per physician's orders.	21545		

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21545	Continued From page 9 During an interview with the director of nursing (DON) on 4/13/23 at 9:21 a.m., she confirmed the torsemide and aspirin enteric coated should have been available in the facility for administration to R87. She stated physician's orders should have been followed for the removal of the resident's lidocaine patch. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for medication errors. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure medication were correctly administered. The quality assurance committee could monitor these measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21545		

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	245298	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/17/2023**

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K 000	INITIAL COMMENTS FIRE SAFETY The Minnesota Department of Public Safety conducted an annual Life Safety recertification survey, State Fire Marshal Division, on 04/17/2023. At the time of this survey, The Estates at 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) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. The Estates at Twin Rivers is a 1-story building with a partial basement that was built in 1962 with an addition in 1977 and was determined to be of Type II (111) construction. The facility is fully protected throughout by an automatic fire sprinkler system. It has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that are monitored for automatic fire department notification. The facility has a capacity of 50 beds and had a census of 36 at the time of the survey. 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.