DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 1, 2021

Administrator
Twin City Gardens
2309 Hayes Street Northeast
Minneapolis, MN 55418

Re: Reinspection Results
Event ID: UTFB12

Dear Administrator:

On September 13, 2021 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 August 5, 2021. 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
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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Electronically delivered
October 1, 2021

Administrator
Twin City Gardens
2309 Hayes Street Northeast
Minneapolis, MN 55418

RE: CCN: 245578
Cycle Start Date: August 5, 2021

Dear Administrator:

On August 20, 2021, we notified you a remedy was imposed. On September 13, 2021 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 September 21, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective October 4, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of August 20, 2021, 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 October 4, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on September 21, 2021, 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 Therefore, the NATCEP prohibition is rescinded.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
Licensing and Certification Program

Electronically delivered
August 20, 2021

Administrator
Twin City Gardens
2309 Hayes Street Northeast
Minneapolis, MN 55418

RE: CCN: 245578
Cycle Start Date: August 5, 2021

Dear Administrator:

On August 5, 2021, a survey was completed at your facility by the Minnesota Department(s) of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 4, 2021.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 4, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 4, 2021.

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

your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by October 4, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Twin City Gardens will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 4, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 5, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

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

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

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

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

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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245578	A. BUILDING _____ B. WING _____	C 08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN CITY GARDENS	**2309 HAYES STREET NORTHEAST MINNEAPOLIS, MN 55418**

(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 8/4/21, to 8/5/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a Focused Infection Control survey. The facility was IN compliance. 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. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 8/4/21, through 8/5/20, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition, a Focused Infection Control survey was also completed. The following complaints were found to be SUBSTANTIATED: H5578051C (MN75231), with a deficiency cited at (F585, F625, and F880). The following complaints were found to be UNSUBSTANTIATED: H5578052C (MN75383). 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.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/24/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 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 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:	F 625		8/31/21

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F 625	Continued From page 2 Based on interview and document review, the facility failed to provide the resident or their representative, a bed hold notice for 1 of 3 residents (R1) reviewed for hospitalizations. R1's admission Minimum Data Set (MDS) dated 7/25/21, identified R1 had intact cognition, and had diagnosis cognitively intact with diagnoses of diabetes and left toe amputation. R1's medical record lacked indication a bed hold notice was provided to R1 or their representative. When interviewed on 8/5/21, at 12:16 p.m. the director of nursing (DON) reported he was unable to locate a bed hold notice after R1 had discharged to the hospital on 7/25/21. When interviewed on 8/5/21, at 2:30 p.m. the administrator confirmed that there was no bed hold notice for R1, and further stated a bed hold was not needed because R1 did not want to return to the facility. The facility policy Bed-Holds and Returns dated 12/16, directed staff: Prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy. Prior to a transfer, written information will be given to the residents and the resident representatives that explains in detail: a. The rights and limitations of the resident regarding bed-holds; b. The reserve bed payment policy as indicated by the state plan (Medicaid residents); c. The facility per diem rate required to hold a bed (non-Medicaid residents), or to hold a bed beyond the state bed-hold period (Medicaid residents);	F 625	This plan of correction and the responses to each F-tag are submitted to maintain certification in the Medicare Medicaid programs and constitute a credible allegation of compliance. The written responses do not constitute an admission of noncompliance or agreement with any findings stated under the F-tags. The facility reserves its right to dispute all findings and deficiencies in any appropriate forum, including in an independent dispute resolution, or, if appealable remedies are subsequently imposed, by timely appeal to the Departmental Appeals Board. Resident R-1 has been discharged from the facility. The facility Administrator has reviewed the policy regarding "Notice of Bed Hold Policy Before/Upon Transfer. Licensed nursing staff and Licensed Social Worker have been educated on facilities policy and procedure regarding notice of bed hold policy before/upon transfer. The facility conducted has conducted a review of all residents to insure compliance with Notice of Bed Hold Policy Before/Upon Transfer. The facility Social Worker and DON shall be responsible for compliance. The facility will conduct audits weekly for two months for compliance, results will be submitted to QAPI Committee monthly for recommendations.	

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F 625	Continued From page 3 and d. The details of the transfer (per the Notice of Transfer).	F 625		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a discharge summary had	F 661	Resident R-1 has been discharged from the facility.	8/31/21

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F 661	Continued From page 4 been completed for 1 of 1 resident (R1) reviewed for transfer and discharges, who was discharged to the hospital. Findings include: R1's admission Minimum Data Set MDS) dated 7/25/21, identified R1 was cognitively intact with diagnoses of diabetes and left toe amputation. R1's medical record lacked indication a discharge summary had been completed after R1 had discharged to the hospital. On 7/25/21, at 6:24 a.m. a progress note indicated R1 independently called the ambulance at 6:10 a.m. because her cares were not being met at the facility. R1's progress notes lacked further documentation that a notice of discharge from the hospital or the facility. When interviewed on 8/5/21, at 12:16 p.m. the director of nursing (DON) confirmed a discharge summary had not been completed for R1 once she was transferred to the hospital. When interviewed on 8/5/21, at 2:30 p.m. the administrator also confirmed a discharge summary had not been completed for R1 once she was transferred to the hospital. The facility policy Discharge Summary and Plan dated 12/16, directed staff: When a resident's discharge is anticipated, a discharge summary and post-discharge plan will be developed to assist the resident to adjust to his/her new living environment. The policy further indicated the discharge summary will include a recapitulation of the resident's stay at this facility and a final	F 661	The facility Administrator has reviewed the policy regarding "Discharge Summary". The interdisciplinary team members have been educated on facilities policy and procedure regarding Discharge Summary. The facility has conducted a review of all residents to insure compliance with Discharge Summary. The facility Social Worker and DON shall be responsible for compliance. The facility will conduct audits weekly for two months for compliance, results will be submitted to QAPI Committee monthly for recommendations.	

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F 661	Continued From page 5 summary of the resident's status at the time of the discharge in accordance with established regulations governing release of resident information and as permitted by the resident. The discharge summary shall include a description of the resident's: a. Current diagnosis; b. Medical history (including any history of mental disorders and intellectual disabilities); c. Course of illness, treatment and/or therapy since entering the facility; d. Current laboratory, radiology, consultation, and diagnostic test results; e. Physical and mental functional status; f. Ability to perform activities of daily living including.	F 661		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual	F 880		8/31/21

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F 880	Continued From page 6 arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and	F 880		

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TWIN CITY GARDENS	**2309 HAYES STREET NORTHEAST MINNEAPOLIS, MN 55418**

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F 880	Continued From page 7 transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure personal protective equipment (PPE) was worn and handled in a manner to reduce the risk of cross-contamination for 2 of 3 residents (R2, R4)reviewed. In addition, the facility failed to ensure residents received their second dose of their COVID-19 vaccine for 3 residents reviewed (R2, R3, R4) during a COVID-19 Infection Control Focused Survey. These findings had potential to affect all 30 residents residing in the facility. Findings include: On 8/4/21, 4:16 p.m. nursing assistant (NA)-B was observed with no eye protection within the hallways of the resident areas on the 2nd floor. NA-B proceeded to enter R2's room and was preparing to assist R2 in changing her incontinent product. NA-B stated he did not have eye protection and would need to locate a pair. On 8/4/21, at 4:34 p.m. NA-C was observed assisting R2 in changing her incontinent product. NA-C pulled down R2's clothing, provided peri-care, and applied a cream to R2. Wearing the same soiled gloves, NA-C applied a clean incontinent brief and pulled up R2's pants. NA-C was interviewed and stated she had worn the same gloves while completing incontinent cares.	F 880	Nursing staff have been educated by the Infection Preventionist on proper PPE requirements. Nursing staff have been educated by the Infection Preventionist on donning/doffing PPE. Nursing staff have been educated by the Infection Preventionist on hand washing with soap and water and also alcohol based hand sanitizer and infection control standards of practice. Resident R2, R3 and R4 have received second vaccination. The facility has vaccinated the remaining residents, all vaccinations have been placed in residents electronic medical record. The facility DON/ADON and Unit Manager shall be responsible for compliance. The facility will conduct audits weekly for two months for compliance, results will be submitted to QAPI Committee monthly for recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245578	A. BUILDING _____ B. WING _____	C 08/05/2021

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F 880	Continued From page 8 On 8/5/21, at 7:30 a.m. NA-A was observed to enter the facility on the main 1st floor and proceeded to wait for the elevator without a surgical mask or eye protection. NA-A confirmed he did not have a mask or eye protection on, because he had just started his shift. NA-A proceeded to take the elevator up the resident areas. On 8/5/21, at 7:30 a.m. NA-D was observed looking out the door of R4's room. NA-D was not wearing eye protection or a surgical mask. NA-D was interviewed and stated she did not have her surgical mask or eye protection on. NA-D stated she had been in there all morning, "I was sweating so I just had to take off my stuff in there and open the door to take a breather. I've been in there all morning, that's why." Review of R2, R3 and R4's electronic medical record for immunizations on 8/4/21, indicated they received their first COVID-19 vaccination on 3/4/21, no further documentation was recorded for a second vaccination. On 8/4/21, at 1:11 p.m. the administrator was interviewed and stated, "For whatever reason they gave some people the first dose [of the COVID-19 vaccine] but did not schedule for the second for whatever reason," which ultimately resulted in 3 residents missing their 2nd COVID-19 vaccination as recommended. The administrator further stated due to director of nursing turnover, the administrator was unable to keep track of the resident's current vaccination status as accurately and appropriately as should have been done On 8/4/21, 4:47 p.m. the director of nursing	F 880		

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F 880	Continued From page 9	F 880		

(DON) stated his expectation for hand hygiene when performing incontinent care was "to clean them and make sure they wash hands after gloving or sanitize before and after. The gloves are getting put into the trash along with the wipes and that's before they touch anything that's clean." The DON confirmed his staff should have either washed her hands with soap and water or used alcohol based hand sanitizer once incontinent cares had been completed.

The facility policy Coronavirus Disease (COVID-19)-Infection Prevention and Control Measures dated 7/20, directed:
Source Control:
I. To address asymptomatic and pre-symptomatic transmission, universal source control is required.
(2) Staff are required to wear face coverings upon entering the facility and prior to leaving the building.
(a) Cloth face coverings for source control ARE NOT considered PPE. Staff should wear a facemask at all times when in the facility.
(b) At the end of shift, staff are required to remove facemask, discard in appropriate receptacle, perform hand hygiene and don a cloth face covering prior to exiting the building.
Personal Protective Equipment:
1. Staff wear facemasks at all times while in the facility, except while eating or drinking in designated areas.
2. Staff wear eye protection during any resident-care encounters or procedures.
3. For a resident with known or suspected COVID-19:
a. Staff wear gloves, isolation gown, eye protection and an N95 or higher-level respirator if available (a facemask is an acceptable alternative if a respirator is not available); and

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F 880	Continued From page 10 b. Resident is placed in a private room with a dedicated bathroom (if available) and closed door; OR c. Resident is cohorted per national, state, or local public health authority recommendations.	F 880		

Electronically delivered
August 20, 2021

Administrator
Twin City Gardens
2309 Hayes Street Northeast
Minneapolis, MN 55418

Re: State Nursing Home Licensing Orders
Event ID: UTFB11

Dear Administrator:

The above facility was surveyed on August 4, 2021 through August 5, 2021 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:

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 8/4/21, to 8/5/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5578051C (MN75231) with licensing orders issued at 0685 and 1930. The following complaint was found to be UNSUBSTANTIATED: H5578052C (MN75383). The Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of	2 000		

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2 000	Continued From page 2 state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 685	MN Rule 4658.0465 Subp. 2 Transfer, Discharge, and Death Subp. 2. Other discharge. When a resident is transferred or discharged for any reason other than death, the nursing home must compile a discharge summary that includes the date and time of transfer or discharge, reason for transfer or discharge, transfer or discharge diagnoses, and condition. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a discharge summary had been completed for 1 of 1 resident (R1) reviewed for transfer and discharges, who was discharged to the hospital. Findings include: R1's admission Minimum Data Set MDS) dated 7/25/21, identified R1 was cognitively intact with diagnoses of diabetes and left toe amputation. R1's medical record lacked indication a discharge summary had been completed after R1 had discharged to the hospital. On 7/25/21, at 6:24 a.m. a progress note indicated R1 independently called the ambulance	2 685	Corrected	8/31/21

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2 685	Continued From page 3 at 6:10 a.m. because her cares were not being met at the facility. R1's progress notes lacked further documentation that a notice of discharge from the hospital or the facility. When interviewed on 8/5/21, at 12:16 p.m. the director of nursing (DON) confirmed a discharge summary had not been completed for R1 once she was transferred to the hospital. When interviewed on 8/5/21, at 2:30 p.m. the administrator also confirmed a discharge summary had not been completed for R1 once she was transferred to the hospital. The facility policy Discharge Summary and Plan dated 12/16, directed staff: When a resident's discharge is anticipated, a discharge summary and post-discharge plan will be developed to assist the resident to adjust to his/her new living environment. The policy further indicated the discharge summary will include a recapitulation of the resident's stay at this facility and a final summary of the resident's status at the time of the discharge in accordance with established regulations governing release of resident information and as permitted by the resident. The discharge summary shall include a description of the resident's: a. Current diagnosis; b. Medical history (including any history of mental disorders and intellectual disabilities); c. Course of illness, treatment and/or therapy since entering the facility; d. Current laboratory, radiology, consultation, and diagnostic test results; e. Physical and mental functional status; f. Ability to perform activities of daily living including.	2 685		

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2 685	Continued From page 4 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures to ensure discharge needs are provided and documented; then inservice staff and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 685		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of	21390		8/31/21

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21390	Continued From page 5 current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure personal protective equipment (PPE) was worn and handled in a manner to reduce the risk of cross-contamination for 2 of 3 residents (R2, R4)reviewed. In addition, the facility failed to ensure residents received their second dose of their COVID-19 vaccine for 3 residents reviewed (R2, R3, R4) during a COVID-19 Infection Control Focused Survey. These findings had potential to affect all 30 residents, staff and visitors residing in the facility. Findings include: On 8/4/21, 4:16 p.m. nursing assistant (NA)-B was observed with no eye protection within the hallways of the resident areas on the 2nd floor. NA-B proceeded to enter R2's room and was preparing to assist R2 in changing her incontinent product. NA-B stated he did not have eye protection and would need to locate a pair. On 8/4/21, at 4:34 p.m. NA-C was observed assisting R2 in changing her incontinent product. NA-C pulled down R2's clothing, provided peri-care, and applied a cream to R2. Wearing the same soiled gloves, NA-C applied a clean incontinent brief and pulled up R2's pants. NA-C was interviewed and stated she had worn the same gloves while completing incontinent cares. On 8/5/21, at 7:30 a.m. NA-A was observed to enter the facility on the main 1st floor and proceeded to wait for the elevator without a	21390	Corrected	

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21390	Continued From page 6	21390		

surgical mask or eye protection. NA-A confirmed he did not have a mask or eye protection on, because he had just started his shift. NA-A proceeded to take the elevator up the resident areas.

On 8/5/21, at 7:30 a.m. NA-D was observed looking out the door of R4's room. NA-D was not wearing eye protection or a surgical mask. NA-D was interviewed and stated she did not have her surgical mask or eye protection on. NA-D stated she had been in there all morning, "I was sweating so I just had to take off my stuff in there and open the door to take a breather. I've been in there all morning, that's why."

Review of R2, R3 and R4's electronic medical record for immunizations on 8/4/21, indicated they received their first COVID-19 vaccination on 3/4/21, no further documentation was recorded for a second vaccination.

On 8/4/21, at 1:11 p.m. the administrator was interviewed and stated, "For whatever reason they gave some people the first dose [of the COVID-19 vaccine] but did not schedule for the second for whatever reason," which ultimately resulted in 3 residents missing their 2nd COVID-19 vaccination as recommended. The administrator further stated due to director of nursing turnover, the administrator was unable to keep track of the resident's current vaccination status as accurately and appropriately as should have been done

On 8/4/21, 4:47 p.m. the director of nursing (DON) stated his expectation for hand hygiene when performing incontinent care was "to clean them and make sure they wash hands after gloving or sanitize before and after. The gloves

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21390	Continued From page 7 are getting put into the trash along with the wipes and that's before they touch anything that's clean." The DON confirmed his staff should have either washed her hands with soap and water or used alcohol based hand sanitizer once incontinent cares had been completed. The facility policy Coronavirus Disease (COVID-19)-Infection Prevention and Control Measures dated 7/20, directed: Source Control: I. To address asymptomatic and pre-symptomatic transmission, universal source control is required. (2) Staff are required to wear face coverings upon entering the facility and prior to leaving the building. (a) Cloth face coverings for source control ARE NOT considered PPE. Staff should wear a facemask at all times when in the facility. (b) At the end of shift, staff are required to remove facemask, discard in appropriate receptacle, perform hand hygiene and don a cloth face covering prior to exiting the building. Personal Protective Equipment: 1. Staff wear facemasks at all times while in the facility, except while eating or drinking in designated areas. 2. Staff wear eye protection during any resident-care encounters or procedures. 3. For a resident with known or suspected COVID-19: a. Staff wear gloves, isolation gown, eye protection and an N95 or higher-level respirator if available (a facemask is an acceptable alternative if a respirator is not available); and b. Resident is placed in a private room with a dedicated bathroom (if available) and closed door; OR c. Resident is cohorted per national, state, or local public health authority recommendations.	21390		

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	00167	A. BUILDING: _____ B. WING _____	C 08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN CITY GARDENS	**2309 HAYES STREET NORTHEAST MINNEAPOLIS, MN 55418**

(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
21390	Continued From page 8 SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee should review/revise facility policies to ensure they contain all components of an infection control program, including daily cumulative tracking and trending of all illnesses in the facility, immediate implementation of droplet precautions to mitigate COVID-19 transmission, and ensure the appropriate use of PPE and prevented from working with symptoms of COVID-19 and cares are being performed appropriately and timely. The DON or designee could educate all staff on existing or revised policies and perform audits to ensure the policies are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. Time Period for Correction: Twenty-one (21) days.	21390		