

Electronically delivered April 13, 2021

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

RE: CCN: 245298

Cycle Start Date: March 9, 2021

Dear Administrator:

On March 29, 2021, we notified you a remedy was imposed. On April 8, 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 March 15, 2021.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective April 13, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of March 29, 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 April 13, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on March 15, 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 Therefore, the NATCEP prohibition is rescinded.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,

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us



Electronically delivered

April 13, 2021

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

Re: Reinspection Results

Event ID: LNAL12

Dear Administrator:

On April 8, 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 March 9, 2021. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

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Saint Paul, Minnesota 55164-0970

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Electronically delivered March 29, 2021

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

RE: CCN: 245298

Cycle Start Date: March 9, 2021

Dear Administrator:

On March 9, 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 isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), 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 April 13, 2021.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective April 13, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 13, 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.

This Department is also recommending that CMS impose:

The Estates At Twin Rivers Llc March 29, 2021 Page 2

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

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 April 13, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, The Estates At Twin Rivers Llc will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 13, 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 Estates At Twin Rivers Llc March 29, 2021 Page 3

- 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), i.e., the plan of correction should be directed to:

Karen Aldinger, Unit Supervisor Metro C District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 85 East Seventh Place, Suite 220 P.O. Box 64900 Saint Paul, Minnesota 55164-0900 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 - 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 September 9, 2021 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C)

The Estates At Twin Rivers Llc March 29, 2021
Page 4
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:

The Estates At Twin Rivers Llc March 29, 2021 Page 5

> 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,

Douglas Larson, Enforcement Specialist

Minnesota Department of Health Licensing and Certification Program

Program Assurance Unit Health Regulation Division

Towers Stapson

Telephone: 651-201-4118 Fax: 651-215-9697

Email: doug.larson@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA

PRINTED: 04/06/2021 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG	COM	IPLETED
						С
		245298	B. WING_		03/	09/2021
	PROVIDER OR SUPPLIER TATES AT TWIN RIVER	RS LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 305 FREMONT STREET ANOKA, MN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	rs .	F 00	00		
	survey was comple complaint investiga NOT to be in compl Requirements for L. The following comp SUBSTANTIATED: The following comp UNSUBSTANTIATE (MN00070663) and The facility's plan of as your allegation of Department's accepenrolled in ePOC, y at the bottom of the form. Upon receipt of an accompled in the policy of the policy of the form. Upon receipt of an accompled in the policy of the form. Treatment/Svcs to I CFR(s): 483.25(b)(1) Press (483.25(b)(1) Press (50.25)	H5298109C (MN00070744). If correction (POC) will serve of compliance upon the otance. Because you are rour signature is not required of first page of the CMS-2567 Cacceptable electronic POC, ander facility may be conducted to notial compliance with the en attained in accordance with Prevent/Heal Pressure Ulcer 1)(i)(ii) egrity	F 68	86		3/15/21
	resident, the facility (i) A resident receiv professional standa pressure ulcers and ulcers unless the in					
LABORATOR	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE
Electron	ically Signed					04/02/2021

(X2) MULTIPLE CONSTRUCTION

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 A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7. BOILDII			c	
		245298	B. WING			09/2021	
NAME OF F	PROVIDER OR SUPPLIEF	3		STREET ADDRESS, CITY, STATE, ZIP CODE			
TUE EST	ATEC AT TWIN DIVE	EDE LL C		305 FREMONT STREET			
IHE EST	ATES AT TWIN RIVE	ERS LLC		ANOKA, MN 55303			
(X4) ID		FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE		(X5)	
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE ROPRIATE	COMPLETION DATE	
F 686	Continued From p	age 1	F 68	86			
		pressure ulcers receives					
		ent and services, consistent					
		standards of practice, to					
		prevent infection and prevent					
	new ulcers from d	eveloping.					
		ENT is not met as evidenced					
	by:						
	Based on interview and document review, the			TAG:			
	facility failed to provide pressure ulcer care per physician orders, and notify the physician when			The facility failed to provide pre			
	they were unable to provide the ordered wound			care per physician orders and in physician when they were unable.			
	care for 1 of 2 residents (R2) reviewed who had			provide the ordered wound car			
		This resulted in actual harm for		residents (R2) reviewed who ha			
		sure ulcer deteriorated, became		pressure ulcers. This resulted i			
		vas hospitalized for sepsis.		harm for R2 when the pressure			
		·		deteriorated, became infected,			
	Findings include:			was hospitalized for sepsis.			
		linimum Data Set (MDS) dated					
		cognitively intact, required		Affected Residents:			
		nce with bed mobility, transfers					
		had 5 stage 4 pressure ulcers		For R2 identified, the resident			
		sue loss with exposed bone,		out to the hospital and discharg			
		Slough or eschar may be parts of the wound bed. Often		from the facility 3/2/2021. The contact the hospital to ensure a			
		ning and tunneling) and 1		information/report and follow up			
		sure ulcer (Full-thickness skin		information/report and follow u	, occurred.		
		which the extent of tissue		Residents at Risk:			
		ulcer cannot be confirmed		The facility completed a full ho	ıse audit		
		ured by slough or eschar),		on 3/2/21 to determine if other			
		sent upon admission. An		the building had skin impairme	າts and or		
	admission MDS h	ad not been completed.		concerns. Follow up was comp was needed.	leted that		
	R2's Braden Scale	e (scale used to determine					
		() dated 2/20/21, identified risk		Policy and Procedures:			
		to bed, very limited mobility,		Skin Assessment and Wound			
		concern. R2 had diagnoses of		Management and Prevention o	f Pressure		
		sis of the legs and lower body),		ulcers/Injuries were reviewed a	nd no		
	needed to be repo	sitioned every 2 hours and had		changes needed.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BUILDIN	<u> </u>		c	
		245298	B. WING _			09/2021	
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP COD	•	03/2021	
				305 FREMONT STREET			
THE EST	ATES AT TWIN RIVE	ERS LLC		ANOKA, MN 55303			
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	CTION	(X5)	
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		OULD BE	COMPLETION DATE	
F 686	1 3		F 68	6			
	a stage 4 pressure	e ulcer on right buttocks.		Education:			
	R2's care plan dat	ed 2/22/21, identified R2 as		EddGallon.			
		on in skin integrity, pressure		Licensed nurses have comple	ed Wound		
		crest (the curved upper border		Management Education and T			
		is the largest of the three		Which includes what to do if u			
bones that form the		ne nip bone), stage 4. Staπ Monitor skin integrity during		complete a treatment as order when to notify a provider/MD.			
		n inspection by nurse.		department staff will be trained			
		areas per order. Monitor for		prevention of pressure ulcers.			
		nd for signs and symptoms of		Management Education and T			
		signs and symptoms to MD		been initiated as of 3/5/21. Ed			
		an assistant. Document on		prevention of pressure ulcers			
	informed.	keep MD/physician assistant		has been initiated as of 3/2/21			
	R2's Physician's o	rders for wound care dated		Licensed Nurses will complete	wound vac		
		staff to, change right iliac crest		competency prior to completing			
	dressing and perfo	orm wound care three times per		vac treatments.	y		
		und thoroughly with Microcyn and cleanser.		Audits:			
		act skin surrounding wound with		Addits.			
		parrier film. Cut wound vac		MD/Provider Communication A	Audit		
	(foam dressing in	the wound bed connected to		The DON and or appropriate of	esignee to		
		d in wound healing) foam		complete audits of skin treatm			
		and apply to wound bed. If		ensure that the MD was notified			
		cin between open areas) be e to intact skin under the foam		concerns per protocol; new wo			
		n injury. Cover foam and		worsening wounds, changes not dressing orders, dressings not			
		ape to achieve seal. Set		signs and symptoms of infection			
		at 125 mm Hg (millimeters of		audit will be completed 2 resid			
	mercury/ a unit of	pressure) continuous. Change		times a week for four weeks, i	successful		
	on evening shift.			it will be titrated to 2 residents			
	D01- 44444			month. If successful, will revie			
		ministration record (TAR) for		QAPI/IDT at that time to determ			
		nowed no documentation from nd vac was on and functioning		additional audits are needed. successful it will be titrated to			
		ft, from admission on 2/19/21,		and then once monthly. If titra	•		
		shift on 2/22/21, three days after		successful. IDT will discuss ar			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245298	B. WING			03/0) 09/2021
NAME OF F	PROVIDER OR SUPPLIER		l	S	TREET ADDRESS, CITY, STATE, ZIP CODE	00/0	70,2021
				30	05 FREMONT STREET		
THE EST	ATES AT TWIN RIVE	RS LLC			NOKA, MN 55303		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	Continued From pa	ige 3	F 6	86			
	admission. No other pressure ulcer on Fidentified. R2's me R2's provider had be	R2's right iliac crest had been dical record did not identify if been notified the wound vac to not been implemented.	-		discontinue.		
	When interviewed a p.m. the Operations Northwestern Resp wound vac and sup intake department vac for R2 on 2/18/delivered the wounday. The driver was a nurse to sign for a When interviewed a p.m. licensed pract worked the evening signing for a wound to facility. LPN-B delivered to the control of the contr	via phone on 3/10/21, at 12:06 is Supervisor (OS) at piratory (company that supplies oplies to the facility) stated the received an order for a wound 21, at 5:00 pm. The driver d vac at 7:15 p.m. that same is required to hand supplies to the delivery of the wound vac. via phone on 3/10/21, at 2:51 ical nurse (LPN)-B stated she g of 2/18/21, and remembered it vac set up that was delivered elivered it to the transitional and placed the package on			Skin Treatment Audits Residents 'dressings and or treatmer records will be audited to ensure the are being completed per orders and proper follow up is occurring. The awill be completed by the DON and compropriate designee. The audits we done on 2 residents 3x a week for 2 weeks. If after two weeks there is not concerns, titration will occur and go residents once a week and then 2 residents monthly. If titration is successful, IDT will discuss and discontinue.	at they I audits or vill be	
	top of the counter a had reported there but could not reme responsible for R2 R2's progress note included, "Patient h [bilateral lower extr right side of hip tha ordered for. Due to	at the nurses station. LPN-B was a delivery to, "someone," mber who. LPN-B was not			The facility failed to provide pressur- care per physician orders and notify physician when they were unable to provide the ordered wound care for residents (R2) reviewed who had pressure ulcers. This resulted in act harm for R2 when the pressure ulce deteriorated, became infected, and was hospitalized for sepsis.	the 1 of 2 tual	
		ound vac comes prior to			Affected Residents:		
	stated she had adn	on 3/9/21, at 11:10 a.m. LPN-A nitted R2 on 2/19/21, and had ds except the one on her iliac			For R2 identified, the resident was sout to the hospital and discharged d from the facility 3/2/2021. The facility contact the hospital to ensure approximately approximat	lirectly ty did	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245298	B. WING		03/0	C 09/2021
	PROVIDER OR SUPPLIER	RS LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 305 FREMONT STREET ANOKA, MN 55303		30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 686	crest, as R2 was he passed the information complete when the not know the woun 2/18/21. R2's progress note included, "New res She c/o [complaine body. Dressing did pain. Resident give as needed] and schelped some, but redelivered this shift. When interviewed am, registered nurs working the evenin R2 was in so much facility. RN-C state care, but R2 refuse wound vac did not reported she did not refusal of wound cahadn't arrived. RN-policy of when to mot aware the wound 2/18/21. R2's progress note included, "Call placout status of wound resent and wound resent research resear	aving too much pain. She ation on to the afternoon shift to a wound vac arrived. LPN-A did d vac had been delivered on a dated 2/19/21, at 10:05 p.m. ident admitted to facility today. Ed of] excruciating pain all over d not get completed due to en PRN [per resident need or heduled pain medications that not enough. Wound vac not	F 686	,	se audit esidents in s and or eted that Pressure d no d Wound ining. ble to I and lursing in Vound ining has eation of ucation	
	provider had been on how to manage	the medical record R2's contacted and orders obtained the wound to her right iliac vac was not available.		Audits: MD/Provider Communication Audits The DON and or appropriate descomplete audits of skin treatmen	signee to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
			A. BUILDI			c	
		245298	B. WING			09/2021	
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COL			
THE E01	ATEO AT TIMINI DIVE	D0.11.0		305 FREMONT STREET			
IHE EST	ATES AT TWIN RIVE	KS LLC		ANOKA, MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 686	p.m. OS at Northwon-call service recordacility had not recordacility had not recordant had already been canother wound vactor then picked up the Wednesday [2/24/2] R2's progress note included, wound vacinterviewed 3/10/2 note, RN-A, clarific	via phone on 3/10/21, at 12:06 estern Respiratory stated, "The eived a call 2/21/21, stating the eived wound vac. Driver was e database that a wound vac delivered 2/18/21; therefore was delivered 2/21/21. We extra wound vac on	F 6	ensure that the MD was notific concerns per protocol; new w worsening wounds, changes in dressing orders, dressings not signs and symptoms of infect audit will be completed 2 residents a week for four weeks, it will be titrated to 2 residents month. If successful, will revise QAPI/IDT at that time to deter additional audits are needed. Successful it will be titrated to and then once monthly. If titra successful, IDT will discuss a discontinue.	ounds, needed to it available, ions. This dents 3 if successful weekly for 1 ew at mine if If once weekly ation is		
	assistant director of wound vac was de incorrect tubing. The improper tubing dereason the wound once delivered." The unsure what, if any between 2/19/21 - 2 wasn't being used. was an issue with a should have been treatment plan. He been notified and received. R2's Initial Wound Summary dated 2/MD-A, identified a right buttocks. The	on 3/10/21, at 10:50 a.m. the of nursing (ADON), stated the divered 2/21/21 with the ne ADON stated that the divery 2/21/21, "was likely the vac wasn't started [2/21/21] ne ADON stated she was yound care had been done 2/22/21, when the wound vac The ADON stated when there the wound vac, the doctor notified for an alternate owever, R2's provider had not no wound care orders had been exaluation and Management 23/21, from a wound physician stage 4 pressure ulcer to the exaluation measured 8 cm 8 cm by 3.1 cm. The wound		Skin Treatment Audits Residents 'dressings and or to records will be audited to ension are being completed per order proper follow up is occurring. Will be completed by the DON appropriate designee. The audone on 2 residents 3x a wee weeks. If after two weeks the concerns, titration will occur a residents once a week and the residents monthly. If titration successful, IDT will discuss a discontinue. Completion Date: 3/15/21	ure that they rs and The audits and or udits will be k for 2 re is no nd go to 2 en 2 is		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245298	B. WING _		03	C / 09/2021	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 305 FREMONT STREET ANOKA, MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 686	under the wound e resulting in a pocke wound's edge) precm at 1 o'clock (loc comparison to the was described as a (yellowish with smabed showed 100% pink in color, and resulting physician ordered times per week on Saturdays. The traight iliac crest dreathree times per we with Microcyn (anti wound cleanser. Furrounding wound film. Cut wound vabed connected to shealing) foam dress wound bed. If brid areas) be sure to a the foam to protect and bridge with vanegative pressure mercury/ a unit of preatment was not on Saturday 2/27/2 identified on 2/25/2 When interviewed a.m. registered nut the evening of 2/27 complete scheduled due to not enough	dges becomes eroded, et beneath the skin at the sent with measurements 2.5 cation of undermining in time on a clock). Drainage moderate sero-sanguineous all amounts of blood). Wound granulation tissue (light red or noist. An indicator of healing). Ininistration record (TAR) for entified R2 was to receive the treatment to the right iliac 3. Tuesdays, Thursdays and eatment ordered was: change essing and perform wound care ek. Irrigate wound thoroughly microbial wound cleanser) at dry. Paint intact skin with Cavilon- no sting barrier ac (foam dressing in the wound sing to fit wound and apply to ging, (intact skin between open apply drape to intact skin under a skin from injury. Cover foam a c drape to achieve seal. Set at 125 mm Hg (millimeters of oressure) continuous. The signed out as being completed et, with the last treatment being	F 68	96			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X'		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		245298	B. WING _		03	C / 09/2021	
	PROVIDER OR SUPPLIER	RS LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 305 FREMONT STREET ANOKA, MN 55303			, 33/33/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH) (EA	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 686	be completed. When interviewed p.m. LPN-C stated 2/27/21, and was rwound care still neright hip. LPN-C dinot been signed out. R2's Wound Evalu Summary dated 3/ noted measurement and the undermining no 'clock. The drains moderate amount usually clear to yell appearance). The 50% slough (yellow dead cells that har fungus, etc and sloincrease the risk or granulation tissue. the wound progres was taken and an arequired surgical dwas added, "Stage buttocks- deteriora. R2's late entry program. included, "At a wound vac was be was clogged, write an extra to replace collects the wound but can't find anyth ask if can deliver the writer spoke will promised to call barrows."	via phone 3/10/21, at 12:29 she worked the evening of not notified by RN-B that the eded to be completed for R2's d not note the treatment had at by the previous shift. ation and Management 1/21, completed by MD-A, nts of 7.2 cm x 6 cm x 3.2 cm. neasurement was 5.2 cm at 5 age was described as of serous (thin and watery and	F 68	6			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG	(X3) DATE SURV COMPLETE	
		245298	B. WING_		03	/ 09/2021
THE ESTATES AT TWIN RIVERS LLC (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 686 Continued From page 8 canister will be delivered in the morning, during business hours, 3.2.21. Res [resident] turn off the machine since it was beeping and distracting Will endorse to the AM nurse." When interviewed 3/10/21, at 10:50 a.m. the ADON stated there were numerous canisters in the box when the wound vac had been delivered and did not be appropriate.			STREET ADDRESS, CITY, STATE, ZIP CO 305 FREMONT STREET ANOKA, MN 55303		ODE	
PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 686	canister will be del business hours, 3. the machine since Will endorse to the When interviewed ADON stated there the box when the vand did not know vavailable to replace there were no can should have contadifferent treatment R2's progress not included, "Resident hospital via Allina Is When interviewed 9:32 a.m. R2 state Northwestern Hosto the nursing hom at the facility starte No other treatment completed while warrive. The wound per week, and the was 2/25/21. The 2/27/21 was not per week, and the was 2/25/21 when the wound care did no 3/2/21 when the woovernight on 3/1/2 beeping and the st stop." She reported wound vac was ful find a replacement	ivered in the morning, during 2.21. Res [resident] turn off it was beeping and distracting. AM nurse." 3/10/21, at 10:50 a.m. the ewere numerous canisters in wound vac had been delivered why there had been none at the canister on 3/2/21. If sters available the nurse cted the provider and request a	F 68	36		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	MULTIPLE CONSTRUCTION UILDING			(X3) DATE SURVEY COMPLETED	
		245298	B. WING				C 09/2021	
	PROVIDER OR SUPPLIER	RS LLC		STREET ADDRESS, CITY, STATE, ZIP C 305 FREMONT STREET ANOKA, MN 55303	ODE	00/		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE	
F 686	wound doctor repor "wasn't clean enouge R2 stated the hip in staph infection (and found on human sk and other areas). When interviewed 3 doctor MD-A stated "looked good" on he nice and granular." she was concerned told her they would hip wound had dete odorous, which was previous week whe the nurse told her th vac cartridge and he vac since the previous week whe the nurse told her they wound, "wasn't cleaved back on." MD-A since the main reach hospital on 3/2/21, uncontrolled pain at [R2] was experience recent spine surger 3/2/21 from MD-A sinfected and MD-A orders and started at the physician assist inform them of her neurosurgery physician surgery physician surgery physician surgery physician assist inform them of her neurosurgery physician assist inform the	ted to her that the wound, gh to restart the wound vac." fection turned out to be a infection caused by a bacteria in, in the nose, armpit, groin, a 3/9/21, at 2:05 p.m. wound the wound on the right hip, er first visit [2/23/21], "it was On the second visit [3/1/21], about the hip wound. [R2] in the change the dressings. The priorated. It was gray and as a, "huge change," from the in had seen it. MD-A stated, hey had issues with the wound adn't been running the wound adn't been running the wound ous night. MD-A was going to ac after wound rounds, but the an enough to put the wound A called the primary ractitioner (NP)-A and told her infected. NP-A decided to Northwestern Hospital.	F 6	86				

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		245298	B. WING_		03	/09/2021		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 305 FREMONT STREET ANOKA, MN 55303		,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 686	and an infectious of unaware that the vibe started on the conot started until 2/2 that on 3/2/21, betwas a problem with there was no replate the machine was to delay in starting the alternate orders, modern 2/27/21, and shutting 3/2/21, would have pressure ulcer. Not been notified of all been notified, wou when interviewed a.m. NP-A stated, notified, "if they do or the ability to do when interviewed a.m. MD-A stated, vac, with no other wound care on 2/2 vac off with no oth the caused deterior pressure ulcer. When interviewed a.m. R2's social whospital stated, "Ray worsening low bace evaluation. They for the Infectious aureus in the blood originating from the resonance imaging from the present the problem of the problem	disease evaluation. NP-A was yound vac that was ordered to day of admission, 2/19/21, was 22/21. NP-A was also unaware ween 2:00 am - 3:00 am, there is the wound vac, and since acement canister in the facility, urned off. NP-A stated, the e wound vac, not obtaining hissed dressing change on ing the wound vac off on e resulted in deterioration of the P-A stated she should have of these issues, and if had ld have made order changes. by phone on 3/11/21, at 9:25 the provider should have been on't have the proper equipment, wound the wound care." by phone on 3/11/21, at 11:03 the delay in starting the wound treatment ordered, the missed ext/21, and shutting the wound er treatment orders could have bration to R2's iliac crest by phone on 3/11/21, at 9:00 orker at Abbott Northwestern extra was readmitted because of the pain and for wound bund she has some infection. Disease note, she has staph do (sepsis) which may be a spine as MRI (magnetic g, a form of x-ray) showed. Per note, they are not clear of the	F 6	36				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION	(X3)	(X3) DATE SURVEY COMPLETED	
		245298	B. WING			C 03/09/2021
	PROVIDER OR SUPPLIER	RS LLC		STREET ADDRESS, CITY, STATE, ZIP (305 FREMONT STREET ANOKA, MN 55303	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATI	(X5) COMPLETION DATE
F 686	origin of the sepsis A Wound Care prodoctober, 2010, indiprovide guidelines promote healing. If following information resident's medical given, the date and given, the position placed, the name aperforming the wounded color, size, drainspecting the wounthe procedure, any by the resident refused the signature and title data. This docume report: Notify the serfuses the wound in accordance with standards of practice. A facility Skin Assemanagement policy provided guidelines wounds. The polic skin problems related document skin con Evaluation weekly, and resident/repression concerns with monthly; update calindicated wound calor provider order; do controlled the sepsion of the	cedure document dated icated the purpose was to for the care of wounds to This document indicated the on should be recorded in the record: the type of wound care I time the wound care was in which the resident was and title of the individual and care, any change in the and, all assessment data (wound inage, etc.) obtained when and, how the resident tolerated problems or complaints made atted to the procedure, if the electreatment and why, and the person recording the ent also included, what to supervisor if the resident care. Report other information facility policy and professional	F 6	86		



Electronically delivered March 29, 2021

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

Re: State Nursing Home Licensing Orders

Event ID: LNAL11

Dear Administrator:

The above facility was surveyed on March 9, 2021 through March 9, 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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at 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

The Estates At Twin Rivers LLC March 29, 2021 Page 2

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

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

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

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

Karen Aldinger, Unit Supervisor Metro C District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 85 East Seventh Place, Suite 220 P.O. Box 64900 Saint Paul, Minnesota 55164-0900 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 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,

Jovens Stapson

Douglas Larson, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program The Estates At Twin Rivers LLC March 29, 2021 Page 3

Program Assurance Unit Health Regulation Division

Telephone: 651-201-4118 Fax: 651-215-9697

Email: doug.larson@state.mn.us

cc: Licensing and Certification File

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00866	B. WING		C 03/09/2021
		00866			1 03/09/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
THE EST	TATES AT TWIN RIVER	2STIC	MONT STREE MN 55303	ĒT .	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETE
2 000	Initial Comments		2 000		
	*****ATTE	NTION*****			
	NH LICENSING	CORRECTION ORDER			
	144A.10, this correct pursuant to a surver found that the deficiency herein are not corrected shall with a schedule of the Minnesota Department.	nether a violation has been			
	requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	rule provided at the tag ille number indicated below. In several items, failure to the items will be considered Lack of compliance upon ny item of multi-part rule will ment of a fine even if the item uring the initial inspection was			
	that may result from orders provided tha the Department witl	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.			
	was conducted to d State Licensure. Yo	S: 8/11/21, an abbreviated survey etermine compliance with ur facility was found to be not the MN State Licensure.			
		laint was found to be 98107C (MN00070564).			

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 04/02/21

STATE FORM 6899 LNAL11 If continuation sheet 1 of 14

TITLE

(X6) DATE

Minnesc	<u>ita Department of He</u>	ealth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			,
		00866	B. WING		1	9/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE EST	TATES AT TWIN RIVER	RSTIC	MONT STREE	ET .		
		ANOKA,	MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 1	2 000			
	Licensing order was	s issued at 0900.				
	Minnesota Department of Health is documenting					
	the State Licensing Correction Orders using Federal software. Tag numbers have been					
		ota state statutes/rules for le assigned tag number				
		eft column entitled "ID Prefix				
	Tag." The state statute/rule out of compliance is					
		ary Statement of Deficiencies" es the "To Comply" portion of				
		r. This column also includes				
		are in violation of the state				
		tement, "This Rule is not met				
		ollowing the surveyor 's ggested Method of Correction				
	and Time Period fo	Correction.				
		participate in the electronic				
	the Minnesota Depart	nsure orders consistent with artment of Health				
	Informational Bullet	in 14-01, available at				
		tate.mn.us/divs/fpc/profinfo/inf				
	delineated on the a	e licensing orders are ttached Minnesota				
		Ith orders being submitted to				
		Although no plan of correction				
		ate Statutes/Rules, please RRECTED" in the box				
		ou must then indicate in the				
		ensure process, under the				
		ndate, the date your orders will be electronically submitting to				
		artment of Health. The facility				
	is enrolled in ePOC	and therefore a signature is				
	-	bottom of the first page of				
	state form.					
	PLEASE DISREGA	RD THE HEADING OF THE				

"PROVIDER'S PLAN OF CORRECTION." THIS

STATE FORM 6899 If continuation sheet 2 of 14 LNAL11

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00866	B. WING		02/0	
		00000			03/0	9/2021
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE EST	TATES AT TWIN RIVER	SIIC STATE	IONT STREE IIN 55303	ET .		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	APPLIES TO FEDE THIS WILL APPEAR	RAL DEFICIENCIES ONLY. R ON EACH PAGE.				
2 900	MN Rule 4658.0525 Ulcers	5 Subp. 3 Rehab - Pressure	2 900			3/15/21
	comprehensive resi of nursing services	sores. Based on the ident assessment, the director must coordinate the ursing care plan which				
	without pressure so pressure sores unle condition demonstra	o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and				
	receives necessary	ho has pressure sores / treatment and services to event infection, and prevent /eloping.				
	by: Based on interview facility failed to prov physician orders, ar they were unable to care for 1 of 2 resid pressure ulcers. Th R2 when the pressure	and document review, the ride pressure ulcer care per nd notify the physician when provide the ordered wound ents (R2) reviewed who had his resulted in actual harm for ure ulcer deteriorated, became as hospitalized for sepsis.		Corrected.		
	Findings include:					
		nimum Data Set (MDS) dated ognitively intact, required				

Minnesota Department of Health STATE FORM

6899 LNAL11 If continuation sheet 3 of 14

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	MULTIPLE CONSTRUCTION UILDING:		(X3) DATE SURVEY COMPLETED	
		00866	B. WING		I	C 09/2021	
	PROVIDER OR SUPPLIER	RS LLC 305 FREI	DDRESS, CITY, S MONT STREE MN 55303	TATE, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
2 900	and hygiene. R2 ha (Full thickness tissue tendon or muscle. So present on some paincludes undermining unstageable pressue and tissue loss in we damage within the because it is obscue which were all pressure ulcer risk) factors of confined friction and shear or paraplegic (paralys) needed to be repossueded to be repossueded to be repossueded to right iliac or of the ileum which is bones that form the were directed to: No cares. Weekly skin Treatment to open skin breakdown and infection. Report si (doctor) or physicial skin condition and linformed. R2's Physician's ore	ge 3 the with bed mobility, transfers and 5 stage 4 pressure ulcers are loss with exposed bone, arts of the wound bed. Oftening and tunneling) and 1 are ulcer (Full-thickness skin which the extent of tissue ulcer cannot be confirmed ared by slough or eschar), ent upon admission. And not been completed. (scale used to determine dated 2/20/21, identified risk to bed, very limited mobility, oncern. R2 had diagnoses of as of the legs and lower body), itioned every 2 hours and had ulcer on right buttocks. If a 2/22/21, identified R2 as a in skin integrity, pressure rest (the curved upper border is the largest of the three a hip bone), stage 4. Staff donitor skin integrity during inspection by nurse. areas per order. Monitor for d for signs and symptoms to MD in assistant. Document on keep MD/physician assistant.	2 900				
	dressing and perfor week. Irrigate would	m wound care three times per nd thoroughly with Microcyn d cleanser) wound cleanser.					

Minnesota Department of Health

STATE FORM 6899 LNAL11 If continuation sheet 4 of 14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00866	B. WING			C 09/2021
	PROVIDER OR SUPPLIER	RSIIC 305 FR	ADDRESS, CITY, S' EMONT STREE A, MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 900	Pat dry. Paint intact Cavilon- no sting by (foam dressing in the suction, to help aid dressing to fit wour bridging, (intact ski sure to apply drape to protect skin from bridge with vac dranegative pressure a mercury/ a unit of pon evening shift. R2's treatment adm February 2021, shot to ensure the woun properly every shift until the evening shadmission. No other pressure ulcer on Fidentified. R2's me R2's provider had bright iliac crest had When interviewed when, the Operations Northwestern Respwound vac and supintake department vac for R2 on 2/18/delivered the wounday. The driver was a nurse to sign for a wound to facility. LPN-B defining the signing for a wound to facility. LPN-B defining the signing for a wound to facility. LPN-B defining the signing for a wound to facility. LPN-B defining the signing for a wound to facility. LPN-B defining the signing for a wound to facility. LPN-B defining the signing for a wound to facility. LPN-B defining the signing for a wound to facility. LPN-B defining the signing for a wound to facility. LPN-B defining the signing for a wound to facility. LPN-B defining the signing for a wound to facility. LPN-B defining the signing for a wound to facility. LPN-B defining the signing for a wound to facility. LPN-B defining the signing for a wound to facility. LPN-B defining the signing for a wound to facility. LPN-B defining the signing for a wound to facility.	et skin surrounding wound with arrier film. Cut wound vache wound bed connected to in wound healing) foam and and apply to wound bed. It in between open areas) be to intact skin under the foam injury. Cover foam and pe to achieve seal. Set at 125 mm Hg (millimeters of oressure) continuous. Chang ministration record (TAR) for owed no documentation from ad vac was on and functioning, from admission on 2/19/21, aft on 2/22/21, three days after treatment to the stage 4 R2's right iliac crest had been adical record did not identify if on the peen notified the wound vac in not been implemented. Wia phone on 3/10/21, at 12:0 as Supervisor (OS) at orientory (company that supplies to the facility) stated the pecived an order for a wound 21, at 5:00 pm. The driver did vac at 7:15 p.m. that same are required to hand supplies to the delivery of the wound vac via phone on 3/10/21, at 2:51 ical nurse (LPN)-B stated she gof 2/18/21, and remembered to vac set up that was delivered to the transitional and placed the package on	e e e e e e e e e e e e e e e e e e e			

Minnesota Department of Health

STATE FORM 6899 LNAL11 If continuation sheet 5 of 14

TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 2 900 Continued From page 5 top of the counter at the nurses station. LPN-B had reported there was a delivery to, "someone," but could not remember who. LPN-B was not responsible for R2 that evening. R2's progress note dated 2/19/21, at 3:24 p.m. included, "Patient has many wounds on BLE [bilateral lower extremities] and one wound on right side of hip that a wound vac has been ordered for. Due to severe pain, wound on right hip was not measured and PM nurse was notified to measure when wound vac comes prior to placing on wound." When interviewed on 3/9/21, at 11:10 a.m. LPN-A stated she had admitted R2 on 2/19/21, and had measured all wounds except the one on her iliac crest, as R2 was having too much pain. She passed the information on to the afternoon shift to complete when the wound vac arrived. LPN-A did not know the wound vac had been delivered on 2/18/21.		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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) 2 900 Continued From page 5 top of the counter at the nurses station, LPN-B had reported there was a delivery to, "someone," but could not remember who. LPN-B was not responsible for R2 that evening. R2's progress note dated 2/19/21, at 3:24 p.m. included, "Patient has many wounds on BLE [bilateral lower extremities] and one wound on right side of hip that a wound vac has been ordered for. Due to severe pain, wound on right hip was not measured and PM nurse was notlified to measure when wound vac comes prior to placing on wound." When interviewed on 3/9/21, at 11:10 a.m. LPN-A stated she had admitted R2 on 2/19/21, and had measured all wounds except the one on her iliac crest, as R2 was having too much pain. She passed the information on to the afternoon shift to complete when the wound vac arrived. LPN-A did not know the wound vac had been delivered on 2/18/21.			00866	B. WING		I	_	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 900 Continued From page 5 top of the counter at the nurses station. LPN-B had reported there was a delivery to, "someone," but could not remember who. LPN-B was not responsible for R2 that evening. R2's progress note dated 2/19/21, at 3:24 p.m. included, "Patient has many wounds on BLE [bilateral lower extremities] and one wound on right side of hip that a wound vac has been ordered for. Due to severe pain, wound on right hip was not measured and PM nurse was notified to measure when wound vac comes prior to placing on wound." When interviewed on 3/9/21, at 11:10 a.m. LPN-A stated she had admitted R2 on 2/19/21, and had measured all wounds except the one on her iliac crest, as R2 was having too much pain. She passed the information on to the afternoon shift to complete when the wound vac arrived. LPN-A did not know the wound vac had been delivered on 2/18/21.			RS LLC 305 FREI	MONT STREE	,			
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R2's progress note dated 2/19/21, at 10:05 p.m. included, "New resident admitted to facility today. She c/o [complained of] excruciating pain all over body. Dressing did not get completed due to pain. Resident given PRN [per resident need or as needed] and scheduled pain medications that helped some, but not enough. Wound vac not delivered this shift." When interviewed via phone on 3/11/21, at 9:25 am, registered nurse (RN)-C stated she was working the evening R2 was admitted on 2/19/21. R2 was in so much pain when she got to the	ti h b r Fiii [li r c h ti p V s n c p c r 2 Fiii S b p a h c v a v	top of the counter at had reported there wout could not rementer sponsible for R2 to R2's progress note included, "Patient had be responsible of hip that ordered for. Due to hip was not measure when wo lacing on wound." When interviewed on the stated she had admitted she had a	at the nurses station. LPN-B was a delivery to, "someone," mber who. LPN-B was not that evening. dated 2/19/21, at 3:24 p.m. has many wounds on BLE emities] and one wound on the awound vac has been because a severe pain, wound on right and PM nurse was notified wound vac comes prior to con 3/9/21, at 11:10 a.m. LPN-A mitted R2 on 2/19/21, and had do except the one on her iliact eaving too much pain. She attion on to the afternoon shift to wound vac arrived. LPN-A did do vac had been delivered on dated 2/19/21, at 10:05 p.m. ident admitted to facility today. In dent admitted to facility today. In ot get completed due to be present of the pain medications that not enough. Wound vac not with pain and pain medications that ot enough. Wound vac not with pain and pain medications that ot enough. Wound vac not with pain and pain medications that ot enough. Wound vac not with pain and pain medications that ot enough. Wound vac not with pain and pain medications that ot enough. Wound vac not with pain and pain medications that ot enough. Wound vac not with pain and pain medications that ot enough. Wound vac not with pain and pain medications that ot enough. Wound vac not with pain and pain medications that ot enough. Wound vac not with pain and pain medications that ot enough. Wound vac not with pain and pain medications that ot enough. Wound vac not with pain and p		DEFICIENCY)			

Minnesota Department of Health

STATE FORM 6899 LNAL11 If continuation sheet 6 of 14

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		00866	B. WING		l l	C 09/2021
	PROVIDER OR SUPPLIER	305 FREM	ONT STREE	STATE, ZIP CODE ST		
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2 900	refusal of wound cahadn't arrived. RN-policy of when to not not aware the wound 2/18/21. R2's progress note included, "Call plac out status of wound resent and wound of this was 2 days sir was no evidence in provider had been on how to manage crest if the wound of the picked up the wednesday [2/24/2]. R2's progress note included, wound vact then picked up the wednesday [2/24/2]. R2's progress note included, wound vact interviewed 3/10/21 note, RN-A, clarified started, not change admission. When interviewed of assistant director of wound vac was delincorrect tubing. The improper tubing delireason the wound of the wound	are or that the wound vac C was not aware of any facility of the provider. RN-C was not vac had been delivered on dated 2/21/21, at 2:10 p.m. ed to Northwest oxygen to find I vac ordered Friday. Order vac to be delivered this pm." noce R2 was admitted. There the medical record R2's contacted and orders obtained the wound to her right iliac vac was not available. Via phone on 3/10/21, at 12:06 estern Respiratory stated, "The sived a call 2/21/21, stating the sived wound vac. Driver was e database that a wound vac elivered 2/18/21; therefore was delivered 2/21/21. We extra wound vac on	2 900			

Minnesota Department of Health

STATE FORM 6899 LNAL11 If continuation sheet 7 of 14

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00866	B. WING		03/0	9/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
THE EST	TATES AT TWIN RIVER	SILC 305 FREM	MONT STREE	т		
1112 201	AILOAI IVIII KIVLI	ANOKA,	MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 7	2 900			
	unsure what, if any, between 2/19/21 -2 wasn't being used. was an issue with the should have been retreatment plan. Ho	wound care had been done /22/21, when the wound vac The ADON stated when there he wound vac, the doctor lotified for an alternate wever, R2's provider had not o wound care orders had been				
	Summary dated 2/2 MD-A, identified a singht buttocks. The (centimeters) by 5.8 contained undermir under the wound expresulting in a pocker wound's edge) preson at 1 o'clock (loc comparison to the twas described as many (yellowish with small bed showed 100% pink in color, and many R2's treatment admire February 2021, identified as in the color.	Evaluation and Management 23/21, from a wound physician stage 4 pressure ulcer to the wound measured 8 cm 8 cm by 3.1 cm. The wound ning (occurs when the tissue dges becomes eroded, to beneath the skin at the sent with measurements 2.5 ation of undermining in time on a clock). Drainage moderate sero-sanguineous II amounts of blood). Wound granulation tissue (light red or noist. An indicator of healing).				
	times per week on Saturdays. The tre right iliac crest dres three times per week with Microcyn (antir wound cleanser. P surrounding wound film. Cut wound valued connected to shealing) foam dress wound bed. If bridg	reatment to the right iliac 3 Tuesdays, Thursdays and atment ordered was: change sing and perform wound care ek. Irrigate wound thoroughly microbial wound cleanser) at dry. Paint intact skin with Cavilon- no sting barrier c (foam dressing in the wound uction, to help aid in wound sing to fit wound and apply to ging, (intact skin between open oply drape to intact skin under				

Minnesota Department of Health

STATE FORM 6899 LNAL11 If continuation sheet 8 of 14

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00866	B. WING		03/0) 9/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE EST	ATES AT TWIN RIVER	305 FREM	MONT STREE	:T		
	AILOAI IWIN KIVLI	ANOKA, I	MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 8	2 900			
	and bridge with vac negative pressure a mercury/ a unit of p treatment was not s on Saturday 2/27/2 identified on 2/25/2					
	a.m. registered nurs the evening of 2/27 complete scheduled due to not enough t	via phone 3/11/21, at 10:52 se (RN)-B stated she worked /21, and was unable to d wound care during her shift ime. RN-B reported to LPN-C right iliac crest still needed to				
	p.m. LPN-C stated 2/27/21, and was no wound care still need right hip. LPN-C did	via phone 3/10/21, at 12:29 she worked the evening of ot notified by RN-B that the eded to be completed for R2's I not note the treatment had t by the previous shift.				
	Summary dated 3/1 noted measurement The undermining mo'clock. The drainar moderate amount of usually clear to yellow appearance). The wood slough (yellow dead cells that harbfungus, etc and slow increase the risk of granulation tissue. The wound progress was taken and an arequired surgical dead to the wound progress was taken and an arequired surgical dead to the wound progress was taken and an arequired surgical dead to the wound progress was taken and an arequired surgical dead to the wound progress was taken and an arequired surgical dead to the wound progress was taken and an arequired surgical dead to the word of the	wound bed was described as ish/white material. Consists of or organisms like bacteria, w/stop healing process. It can				

Minnesota Department of Health

STATE FORM 6899 LNAL11 If continuation sheet 9 of 14

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>′</i>	E CONSTRUCTION		SURVEY PLETED
			71. 501251110.			c
		00866	B. WING		l l	09/2021
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
THE EST	TATES AT TWIN RIVE	RSTIC	MONT STREE MN 55303	ĒT		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 900	Continued From pa	age 9	2 900			
	buttocks- deteriorated due to infection."					
	a.m. included, "At a wound vac was bed was clogged, writer an extra to replace collects the wound but can't find anyth ask if can deliver the writer spoke will promised to call bac canister will be delibusiness hours, 3.2	gress note dated 3/2/2, 4:05 around 2 to 3 am resident's eping, and upon checking it r and the aide tried to look for the canister [the canister drainage from the wound vac] ing. Contacted the supplier to the canister ASAP and the lady th, will try if the [sic] can and the lady the cand she was told that the evered in the morning, during 2.21. Res [resident] turn off it was beeping and distracting. AM nurse."				
	ADON stated there the box when the wand did not know wavailable to replace there were no canis should have contact different treatment		1			
	included, "Residen	dated 3/2/21, at 5:23 p.m. t sent Abbott Northwestern EMS at 1720 [5:20 p.m.].				
	9:32 a.m. R2 stated Northwestern Hosp to the nursing hom at the facility starte No other treatment completed while wa arrive. The wound	via telephone on 3/9/21, at d, she was sent to Abbott bital 3/2/21. She was admitted e 2/19/21 and stated the staff d the wound vac on 2/22/21. It to her right hip had been aiting for the wound vac to care was ordered for 3 times last date of the wound care				

Minnesota Department of Health

STATE FORM 6899 LNAL11 If continuation sheet 10 of 14

STATEMENT OF DEF AND PLAN OF CORR	ICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				 		
		00866	B. WING		03/0	9/2021
NAME OF PROVIDER	OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE ESTATES AT	TWIN RIVE	RS LLC 305 FREM ANOKA, M	IONT STREE IN 55303	ĒT		
	CH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
was 2/2/27/22 why. Twound 3/2/21 Overni beepin stop." wound find a roff." T care do wound "wasn' R2 star staph i found of and oth When doctor "looked nice ar she was told he hip woo odorou previous the nur vac car vac sin restart wound vac ba physici the wo send R	I was not per the dressing care did not when the word when the standard was full replacement the wound varied the hip in the concerned of good" on him and had determined the would was concerned the would was concerned the would when the would was concerned the would was week when the would was week when the would was to a concerned the would was week when the would was week when the would was week when the would was to and had determined and had determined the would was week when the would was to and had a concerned the would was to and had determined and had a concerned the would was to a	wound care scheduled for rformed, she did not know did not get changed and get completed again until bund care doctor came. 1, the, "machine started aff were unable to get it to d that the canister on the and the staff were "unable to so they turned the wound vac ac remained off until the wound and evaluated the wound. The rted to her that the wound vac." Infection turned out to be a infection caused by a bacteriatin, in the nose, armpit, groin, about the hip wound. [R2] on the second visit [3/1/21], about the hip wound. [R2] on the second visit [3/1/21], about the hip wound. [R2] on the second visit [3/1/21], about the hip wound. [R2] on the second visit [3/1/21], about the hip wound. [R2] on the second visit [3/1/21], about the hip wound. [R2] on the second visit [3/1/21], about the hip wound. [R2] on the second visit [3/1/21], about the hip wound. [R2] on the second visit [3/1/21], about the hip wound. [R2] on the second visit [3/1/21], about the hip wound. [R2] on the second visit [3/1/21], and the wound was night. MD-A was going to rea after wound rounds, but the second visit [3/1/21], at 4:03 p.m. NP-A accided to Northwestern Hospital.	2 900			

Minnesota Department of Health

	na Department of Tie	1	1			-
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
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		00866	B. WING		1	9/2021
			l		1 00/0	0/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE EQ	ATEC AT TWIN DIVE	305 FREN	IONT STREE	T		
IHE ESI	TATES AT TWIN RIVER	ANOKA, I	MN 55303			
(V4) ID	SHMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
(X4) ID PREFIX	-	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO	PRIATE	DATE
				DEFICIENCY)		
2 900	Continued From pa	ne 11	2 900			
2 000	•		2 000			
	hospital on 3/2/21,					
		nd for a wound evaluation.				
		ing increasing pain after her				
		y. NP-A received a call on				
	3/2/21 from MD-A s	tating R2's wound looked				
		had written new wound care				
		antibiotics. NP-A contacted				
		tant for [R2]'s neurosurgeon to				
		uncontrolled pain. The				
		cian assistant requested [R2]				
		gency department for imaging				
	and an infectious di	isease evaluation. NP-A was				
		ound vac that was ordered to				
		ay of admission, 2/19/21, was				
	not started until 2/2	2/21. NP-A was also unaware				
	that on 3/2/21, betw	veen 2:00 am - 3:00 am, there				
	was a problem with	the wound vac, and since				
	there was no replace	cement canister in the facility,				
	the machine was tu	rned off. NP-A stated, the				
	delay in starting the	wound vac, not obtaining				
	alternate orders, m	issed dressing change on				
		ng the wound vac off on				
	3/2/21, would have	resulted in deterioration of the				
		-A stated she should have				
	been notified of all	of these issues, and if had				
		d have made order changes.				
		by phone on 3/11/21, at 9:25				
	a.m. NP-A stated, t	he provider should have been				
		I't have the proper equipment,				
	or the ability to do v	vound the wound care."				
		by phone on 3/11/21, at 11:03				
		he delay in starting the wound				
		reatment ordered, the missed				
	wound care on 2/27	7/21, and shutting the wound				
		r treatment orders could have				
	the caused deterior	ation to R2's iliac crest				
	pressure ulcer.					
	•					
	When interviewed by	by phone on 3/11/21, at 9:00				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED					
		00866	B. WING			C 09/2021					
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE							
THE ESTATES AT TWIN RIVERS LLC 305 FREMONT STREET ANOKA, MN 55303											
(X4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF COI		(VE)					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE					
	a.m. R2's social worker at Abbott Northwestern Hospital stated, "R2 was readmitted because of worsening low back pain and for wound evaluation. They found she has some infection. Per the Infectious Disease note, she has staph aureus in the blood (sepsis) which may be originating from sacral wound, or may be originating from the spine as MRI (magnetic resonance imaging, a form of x-ray) showed. Per infectious disease note, they are not clear of the origin of the sepsis." A Wound Care procedure document dated October, 2010, indicated the purpose was to provide guidelines for the care of wounds to promote healing. This document indicated the following information should be recorded in the resident's medical record: the type of wound care given, the date and time the wound care was										
	given, the position in placed, the name as performing the wous resident's condition bed color, size, drait inspecting the woust the procedure, any by the resident related resident refused the signature and title codata. This docume report: Notify the strefuses the wound in accordance with standards of practice. A facility Skin Assess Management policy provided guidelines wounds. The policy	n which the resident was nd title of the individual nd care, any change in the , all assessment data (wound inage, etc.) obtained when nd, how the resident tolerated problems or complaints made ted to the procedure, if the extreatment and why, and the of the person recording the nt also included, what to supervisor if the resident care. Report other information facility policy and professional ce.									

Minnesota Department of Health

STATE FORM 6899 LNAL11 If continuation sheet 13 of 14

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED							
			A. BOILDING.	·		,						
00866		B. WING		03/09/2021								
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	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE						
2 900	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 13 document skin condition on the Pressure Wound Evaluation weekly, until healed; update provider and resident/representative as needed; review skin concerns with interdisciplinary team at least monthly; update care plan as needed. It also indicated wound care will be provided per nursing or provider order; document treatment or refusal of treatment in the resident's medical record. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcers. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		2 900									

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