Electronically delivered

September 10, 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 informed you of imposed enforcement remedies.

On August 23, 2021, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey findings:

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

This Department continues to recommend that CMS impose a 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.

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.

As we notified you in our letter of August 20, 2021, in accordance with Federal law, as specified in the

Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 4, 2021.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

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:

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 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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/ 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 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
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 08/23/2021

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
F 000	INITIAL COMMENTS On 8/23/21, 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. The following complaints were found to be SUBSTANTIATED: H5578056C (MN75777) A deficiency will be cited at F697. H5578055C (MN75675) A deficiency will be cited at F697. H5578054C (MN75326, MN75373) A deficiency will be cited at F697. H5578053C (MN75675) A deficiency will be cited at F697. An unrelated citation will be cited at F761 at an E level. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is	F 697		9/21/21

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

Electronically Signed | 09/15/2021

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F 697	Continued From page 1 provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure adequate pain management for 1 of 1 residents (R1) reviewed for pain management. Finding include: R1's Face Sheet printed 8/23/21, indicated diagnoses which included atrial fibrillation (irregular heart rate), osteoporosis, obesity, and diabetes. R1's annual Minimum Data Set (MDS) dated 6/11/21, indicated R1 was cognitvly intact, and was unable to walk and required a high level of assistance to get into his wheel chair. R1's Physicain orders, dated 8/10/21, stated that pain management medication for 'as needed' (PRN) oxycodone hcl pain medication 5 milligrams every six hours and an oxycontin 10mg extended release (ER) 12 hours tablet scheduled every night at bedtime. The pain medication was being used for chronic back pain and mouth pain after oral surgery with teeth removal. R1's care plan, dated 8/5/21 upon readmission to the facility, indicates that, "the resident will be free of any discomfort or adverse side effects from pain medication through the review date." It also indicated, "Administer ANALGESIC medications as ordered by physician.	F 697	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. R1 has been reassessed for pain, per physician order pain management has been changed from prn to scheduled. Education to License staff includes Medication orders, Medication Administration and documenting pain in the EMAR. All residents are assessed for pain q shift. Pain will be monitored q shift on the MAR by DON/designee. Audits will be performed by DON/designee weekly for one month. Compliance results will be submitted to QAPI committee for recommendations.	

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F 697	Continued From page 2	F 697		

Monitor/document side effects and effectiveness Q-SHIFT."

On 8/23/21, at 9:29 a.m. R1 was interviewed and stated his pain was not being properly managed, and the facility failed to provide him with his pain medication as he had requested and as it was was ordered. R1 said he was allowed to have the medication every six hours, but usually only got it two times per day. R1 stated it would often take staff three to four hours give him his pain medication after he requested it. R1 stated he had only gotten his pain medication twice in the past 24 hours. During the interview, R1 was not showing any signs or symptoms of pain, but did verbalize he was experiencing pain.

On 8/23/21, at 11:16 a.m. trained medication aide (TMA)-A was interviewed. TMA-A stated R1 was able to get his pain medication every six hours. TMA-A stated R1 asked for his pain medication more frequently than he was allowed to have it. TMA-A stated R1 had been talked to about this multiple times by nursing staff and his nurse practitioner (NP)-A.

On 8/23/21, at 11:32 a.m. registered nurse (RN)-A was interviewed and stated R1 was always asking for his pain medication. RN-A stated R1 could only have his pain medication every six hours, however, he would ask for it more frequently than he was allowed.

On 8/23/21, at 11:43 a.m.the assistant director of nursing (ADON) was interviewed and stated R1 had PRN pain medication for pain management.The ADON stated R1 wanted the pain medication more than he was allowed to have it. The ADON stated R1's NP had referred

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F 697	Continued From page 3	F 697		

R1 to a pain clinic to figure out what could be done to help with his pain management.

On 8/23/21, at 12:00 p.m. social worker (SW)-A was interviewed and stated R1 complained of pain and requested pain medication often. SW-A stated R1 had been referred to a pain clinic recently to figure out how to best manage his pain due to his history of opioid abuse.

On 8/23/21, at 1:42 p.m. the director of nursing (DON) was interviewed and stated R1's NP wanted to get him to a pain clinic, and was not comfortable prescribing more pain medication. The DON stated the pain clinic requested R1 have a magnetic resonance imaging (MRI), and this was scheduled for 9/1/21. At 2:47 p.m. the DON was inetrviewed angain and stated R1 should have been allowed to get his pain medication when he requested so long as it followed the prescribed orders. The DON stated R1 was getting all of the doses of oxycodone pain medication he requested every six hours. The DON reviewed R1's medication administration record (MAR) which showed that R1 was not getting pain medication doses as prescribed or as requested by R1. The DON then stated R1 had not been getting his allowed doses of oxycodone as prescribed.

R1's orders for oxycodone allowed for 4 doses every 24 hours. R1's MAR dated 8/10/21, to 8/22/21, indicated R1 had received the following doses:

8/10/21, one dose
8/11/21, two doses
8/12/21, three doses
8/13/21, three doses

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F 697	Continued From page 4 8/14/21, two doses 8/15/21, one dose 8/16/21, one dose 8/17/21, zero dose 8/18/21, two doses 8/19/21, two doses 8/20/21, two doses 8/21/21, two doses 8/22/21, two doses The facility policy Administering Medication dated, last revised April 2019, directed PRN medication orders were to be followed and made available to residents as they requested them.	F 697		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 761		9/21/21

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F 761	Continued From page 5 abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure that the medication room door remained closed and locked to prevent residents from having access to medications that were in the medication room. This had the potential to affect all residents on the 2nd floor. Findings include: On 8/23/21, at 8:28 a.m. the medication room door on the 2nd floor located next to the nursing station was observed to be open. Staff were not present to monitor the door. On 8/23/21, at 10:16 a.m. the medication room door on the 2nd floor was observed to be open without staff members present to monitor the door. On 8/23/21, at 11:25 a.m. the medication room door on the 2nd floor was observed to be open without staff members present to monitor the door. On 8/23/21, at 11:43 a.m. the assistant director of nursing (ADON) was interviewed. the ADON stated narcotics were not stored in the medication room and only in medication carts. The ADON stated other medications would be stored in the medication room, including insulin and stock medications. The ADON stated she would expect the medication room door be kept closed and	F 761	Second floor medication room door has been secured. Signage has been placed on keeping medication door closed. Licensed staff educated on medication room door closed at all times. Safety and Supervision of Resident Policy has been reviewed by LNHA and DON. Audits of secured medication room door will be completed weekly for one month. Compliance results will be submitted to QAPI committee for recommendations.	

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F 761	Continued From page 6 locked at all times. The facility policy Administering Medications revised 4/19/21, lacked direction on locking the medication room door when no staff were in the area.	F 761		

Electronically delivered
September 10, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: T6Q511

Dear Administrator:

The above facility was surveyed on August 23, 2021 through August 23, 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
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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	00167	A. BUILDING: _____ B. WING _____	C 08/23/2021

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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 8/23/21, 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00167	A. BUILDING: _____ B. WING _____	C 08/23/2021

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

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5578056C (MN75777) A licensing order will be issued at 0830. H5578055C (MN75675) A licensing order will be issued at 0830. H5578054C (MN75326, MN75373) A licensing order will be issued at 0830. H5578053C (MN75675) A licensing order will be issued at 0830. An unrelated licensing order will be issued at 1610. 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	2 000		

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2 000	Continued From page 2 available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure adequate pain management for 1 of 1 residents (R1) reviewed for pain management.	2 830	Corrected	9/21/21

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2 830	Continued From page 3 Finding include: R1's Face Sheet printed 8/23/21, indicated diagnoses which included atrial fibrillation (irregular heart rate), osteoporosis, obesity, and diabetes. R1's annual Minimum Data Set (MDS) dated 6/11/21, indicated R1 was cognitvly intact, and was unable to walk and required a high level of assistance to get into his wheel chair. R1's Physicain orders, dated 8/10/21, stated that pain management medication for 'as needed' (PRN) oxycodone hcl pain medication 5 milligrams every six hours and an oxycontin 10mg extended release (ER) 12 hours tablet scheduled every night at bedtime. The pain medication was being used for chronic back pain and mouth pain after oral surgery with teeth removal. R1's care plan, dated 8/5/21 upon readmission to the facility, indicates that, "the resident will be free of any discomfort or adverse side effects from pain medication through the review date." It also indicated, "Administer ANALGESIC medications as ordered by physician. Monitor/document side effects and effectiveness Q-SHIFT." On 8/23/21, at 9:29 a.m. R1 was interviewed and stated his pain was not being properly managed, and the facility failed to provide him with his pain medication as he had requested and as it was was ordered. R1 said he was allowed to have the medication every six hours, but usually only got it two times per day. R1 stated it would often take staff three to four hours give him his pain	2 830		

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2 830	Continued From page 4 medication after he requested it. R1 stated he had only gotten his pain medication twice in the past 24 hours. During the interview, R1 was not showing any signs or symptoms of pain, but did verbalize he was experiencing pain. On 8/23/21, at 11:16 a.m. trained medication aide (TMA)-A was interviewed. TMA-A stated R1 was able to get his pain medication every six hours. TMA-A stated R1 asked for his pain medication more frequently than he was allowed to have it. TMA-A stated R1 had been talked to about this multiple times by nursing staff and his nurse practitioner (NP)-A. On 8/23/21, at 11:32 a.m. registered nurse (RN)-A was interviewed and stated R1 was always asking for his pain medication. RN-A stated R1 could only have his pain medication every six hours, however, he would ask for it more frequently than he was allowed. On 8/23/21, at 11:43 a.m.the assistant director of nursing (ADON) was interviewed and stated R1 had PRN pain medication for pain management.The ADON stated R1 wanted the pain medication more than he was allowed to have it. The ADON stated R1's NP had referred R1 to a pain clinic to figure out what could be done to help with his pain management. On 8/23/21, at 12:00 p.m. social worker (SW)-A was interviewed and stated R1 complained of pain and requested pain medication often. SW-A stated R1 had been referred to a pain clinic recently to figure out how to best manage his pain due to his history of opioid abuse. On 8/23/21, at 1:42 p.m. the director of nursing (DON) was interviewed and stated R1's NP	2 830		

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2 830	Continued From page 5 wanted to get him to a pain clinic, and was not comfortable prescribing more pain medication. The DON stated the pain clinic requested R1 have a magnetic resonance imaging (MRI), and this was scheduled for 9/1/21. At 2:47 p.m. the DON was inetrviewed angain and stated R1 should have been allowed to get his pain medication when he requested so long as it followed the prescribed orders. The DON stated R1 was getting all of the doses of oxycodone pain medication he requested every six hours. The DON reviewed R1's medication administration record (MAR) which showed that R1 was not getting pain medication doses as prescribed or as requested by R1. The DON then stated R1 had not been getting his allowed doses of oxycodone as prescribed. R1's orders for oxycodone allowed for 4 doses every 24 hours. R1's MAR dated 8/10/21, to 8/22/21, indicated R1 had received the following doses: 8/10/21, one dose 8/11/21, two doses 8/12/21, three doses 8/13/21, three doses 8/14/21, two doses 8/15/21, one dose 8/16/21, one dose 8/17/21, zero dose 8/18/21, two doses 8/19/21, two doses 8/20/21, two doses 8/21/21, two doses 8/22/21, two doses The facility policy Administering Medication dated, last revised April 2019, directed PRN medication orders were to be followed and made available to	2 830		

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2 830	Continued From page 6 residents as they requested them. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures that addresses following provider orders for 'as needed' medication for pain management. . The DON or designee could educate all appropriate staff on the policies and procedures for 'as needed' pain medication use. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure that the medication room door remained closed and locked to prevent residents from having access to medications that were in the medication room. This had the potential to affect all residents on the 2nd floor. Findings include:	21610	Corrected	9/21/21

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21610	Continued From page 7 On 8/23/21, at 8:28 a.m. the medication room door on the 2nd floor located next to the nursing station was observed to be open. Staff were not present to monitor the door. On 8/23/21, at 10:16 a.m. the medication room door on the 2nd floor was observed to be open without staff members present to monitor the door. On 8/23/21, at 11:25 a.m. the medication room door on the 2nd floor was observed to be open without staff members present to monitor the door. On 8/23/21, at 11:43 a.m. the assistant director of nursing (ADON) was interviewed. the ADON stated narcotics were not stored in the medication room and only in medication carts. The ADON stated other medications would be stored in the medication room, including insulin and stock medications. The ADON stated she would expect the medication room door be kept closed and locked at all times. The facility policy Administering Medications revised 4/19/21, lacked direction on locking the medication room door when no staff were in the area. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures that address medication room security and storage expectations. The DON or designee could educate all appropriate staff on the policies and procedures for medication room security and storage	21610		

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21610	Continued From page 8 expections. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21610		