

Protecting, Maintaining and Improving the Health of All Minnesotans

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

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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 Twin City Gardens September 10, 2021

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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

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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: <a href="https://mdhprovidercontent.web.health.state.mn.us/ltc">https://mdhprovidercontent.web.health.state.mn.us/ltc</a> 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

Twin City Gardens September 10, 2021 Page 5

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

Kamala Fishe Downing

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: Kamala.Fiske-Downing@state.mn.us

PRINTED: 09/15/2021 FORM APPROVED OMB NO. 0938-0391

| Page   Provider or supplier   Provider or supplier or suppl  |        | OF DEFICIENCIES OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |     |   | (X3) DATE SURVEY<br>COMPLETED |            |
|---|--------|---|---|---|-----|---|-------------------------------|------------|
| TWIN CITY GARDENS    SUMMARY STATEMENT OF DEFICIENCIES   2009 HAYES STREET ADDRESS, CITY, STATE, JEY CODE 2309 HAYES STREET ADDRESS, CITY, STATE, JEY CODE 2309 HAYES STREET NORTHEAST   MINNEAPOLIS, MN 55418  |        |   | 245578  | B. WING                                 |     |   |                               |            |
| PRÉÉIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  FOOD 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 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. An unrelated citation 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 697 SS=D CFR(s): 483.25(k)  §483.25(k) Pain Management. The facility must ensure that pain management is   |        |   |   |   | 230 | 09 HAYES STREET NORTHEAST                                     | 1 001                         | 20,2021    |
| 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 (MN7577) A deficiency will be cited at F697. H5578056C (MN75875) A deficiency will be cited at F697. H5578054C (MN75326, MN75373) 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 697 S=D  F 697 S=D  F 697 S=D   | PRÉFIX | (EACH DEFICIENCY  | Y MUST BE PRECEDED BY FULL  | PREFIX                                  | ×   | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP | BE                            | COMPLETION |
| 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. H5578056C (MN75675) A deficiency will be cited at F697. H5578056C (MN75326, MN75373) A deficiency will be cited at F697. H5578056C (MN75675) 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 697  F 697  S=D  F 697  | F 000  | INITIAL COMMEN  | TS  | F0                                      | 00  |   |                               |            |
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Electronically Signed

O9/15/2021

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for pursing homes, the findings stated above are disclosable 90 days.

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: |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING |  | (X3) DATE SURVEY<br>COMPLETED  |                            |
|--|--|---|--|--|--|----------------------------|
|  |  | 245578  | B. WING                                |  | 1  | C<br><b>23/2021</b>        |
|  | PROVIDER OR SUPPLIER   |   |  | STREET ADDRESS, CITY, STATE, ZIP COD<br>2309 HAYES STREET NORTHEAST<br>MINNEAPOLIS, MN 55418                       |  | 20/2021                    |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                    | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE API<br>DEFICIENCY)               | OULD BE  | (X5)<br>COMPLETION<br>DATE |
| F 697  | consistent with profithe comprehensive and the residents' of This REQUIREMENT by:  Based on observative, the facility from the facility fr | ts who require such services, ressional standards of practice, person-centered care plan, goals and preferences.  NT is not met as evidenced stion, interview, and document ailed to ensure adequate pain of 1 residents (R1) reviewed ent.  inted 8/23/21, indicated cluded atrial fibrillation by, osteoporosis, obesity, and and required a high level of to his wheel chair.  ers, dated 8/10/21, stated that medication for 'as needed' not pain medication 5 or hours and an oxycontine ease (ER) 12 hours tablet ght at bedtime. The pain ng used for chronic back pain er oral surgery with teeth | F 697                                  | ,  | maintain edicaid dible written n admission nt with any ys. The bute all y an n, or, if equently ne ain, per nent has eduled. udes ng pain in pain q shift. |                            |
|  | the facility, indicate<br>free of any discomf<br>from pain medication  | ed 8/5/21 upon readmission to es that, "the resident will be ort or adverse side effects on through the review date." It minister ANALGESIC ered by physician.  |  | Audits will be performed by DON/designee weekly for one Compliance results will be sub QAPI committee for recommen | mitted to  |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTII<br>A. BUILDIN  | PLE CONSTRUCTION  G   |   | (X3) DATE SURVEY<br>COMPLETED  |                            |
|--|--|--|---|---|--------------------------------|----------------------------|
|  |  | 245578   | B. WING   |   | 08                             | C<br>/ <b>23/2021</b>      |
|  | PROVIDER OR SUPPLIER   |  | STREET ADDRESS, CITY, STATE, ZIP CODE 2309 HAYES STREET NORTHEAST MINNEAPOLIS, MN 55418 |   | CODE                           | 72072021                   |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTION<br>(EACH CORRECTIVE ACTION<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EA | ON SHOULD BE<br>IE APPROPRIATE | (X5)<br>COMPLETION<br>DATE |
| F 697  | On 8/23/21, at 9:29 stated his pain was and the facility faile medication as he h was ordered. R1 s medication every s two times per day. staff three to four h medication after he had only gotten his past 24 hours. Duri showing any signs verbalize he was expended by the stated R1 at a more frequently that TMA-A stated R1 at multiple times by no practitioner (NP)-A On 8/23/21, at 11:3 (RN)-A was intervially as asking for his stated R1 could on every six hours, ho more frequently that On 8/23/21, at 11:4 nursing (ADON) was had PRN pain medication medication medication in the stated R1 pain medication medication as he shall be stated R1 could on every six hours, ho more frequently that on 8/23/21, at 11:4 nursing (ADON) was had PRN pain medication as he shall be stated R1 could on every six hours, ho more frequently that the stated R1 could on every six hours, ho more frequently that the stated R1 could on every six hours, ho more frequently that the stated R1 could on every six hours, ho more frequently that the stated R1 could on every six hours, ho more frequently that the stated R1 could on every six hours, ho more frequently that the stated R1 could on every six hours, ho more frequently that the stated R1 could on every six hours, ho more frequently that the stated R1 could on every six hours, ho more frequently that the stated R1 could on every six hours, ho more frequently that the stated R1 could on every six hours, ho more frequently that the stated R1 could on every six hours, ho more frequently that the stated R1 could on every six hours, ho more frequently that the stated R1 could on every six hours, ho more frequently that the stated R1 could on every six hours, ho more frequently that the stated R1 could on every six hours, ho more frequently that the stated R1 could on every six hours, ho more frequently that the stated R1 could on ever | a.m. R1 was interviewed and a not being properly managed, d to provide him with his pain ad requested and as it was aid he was allowed to have the ix hours, but usually only got it R1 stated it would often take ours give him his pain a requested it. R1 stated he pain medication twice in the ng the interview, R1 was not or symptoms of pain, but did experiencing pain.  6 a.m. trained medication aide riewed. TMA-A stated R1 was medication every six hours. sked for his pain medication an he was allowed to have it. ad been talked to about this ursing staff and his nurse ewed and stated R1 was its pain medication. RN-A ly have his pain medication wever, he would ask for it an he was allowed.  3 a.m.the assistant director of as interviewed and stated R1 | F 69  | 7   |                                |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING   |                     |  | (X3) DATE SURVEY<br>COMPLETED |                            |
|--|---|---|---------------------|--|-------------------------------|----------------------------|
|  |   | 245578  | B. WING _           |  | 08                            | C<br>/ <b>23/2021</b>      |
|  | PROVIDER OR SUPPLIER  |   |                     | STREET ADDRESS, CITY, STATE, ZIP C<br>2309 HAYES STREET NORTHEAST<br>MINNEAPOLIS, MN 55418 | CODE                          | .20,2021                   |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | N SHOULD BE                   | (X5)<br>COMPLETION<br>DATE |
| F 697  | R1 to a pain clinic to done to help with home to help with home to help with home to help with home as interviewed an pain and requested stated R1 had been recently to figure or due to his history of the home to his history of the home to get him to comfortable prescribed.  On 8/23/21, at 1:42 (DON) was interviewed to get him to comfortable prescribed have a magnetic rethis was scheduled DON was inetrviewed home to help with the prescribed have been a medication when help help with the prescribed have getting all commedication he required to help with the prescribed have been getting his as prescribed.  R1's orders for oxygevery 24 hours. R1 | of figure out what could be is pain management.  O p.m. social worker (SW)-A d stated R1 complained of pain medication often. SW-A referred to a pain clinic at how to best manage his pain f opioid abuse.  I p.m. the director of nursing wed and stated R1's NP or a pain clinic, and was not be pain clinic requested R1 sonance imaging (MRI), and for 9/1/21. At 2:47 p.m. the ed angain and stated R1 allowed to get his pain the requested so long as it be orders. The DON stated of the doses of oxycodone pain ested every six hours. The se medication administration in showed that R1 was not ation doses as prescribed or as the DON then stated R1 had allowed doses of oxycodone codone allowed for 4 doses as MAR dated 8/10/21, to R1 had received the following | F 69                | 7  |                               |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING |   |  | ` '                 | TE SURVEY<br>MPLETED  |        |                            |
|--|---|--|---------------------|---|--------|----------------------------|
|  |   | 245578   | B. WING             |   | 08     | C<br>/ <b>23/2021</b>      |
|  | PROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2309 HAYES STREET NORTHEAST<br>MINNEAPOLIS, MN 55418     |        |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI)<br>TAG | PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE | (X5)<br>COMPLETION<br>DATE |
|  | last revised April 20 orders were to be foresidents as they re Label/Store Drugs at CFR(s): 483.45(g)(https://doi.org/10.1016/j.com/s483.45(g) Labeling Drugs and biological labeled in accordan professional princip appropriate access instructions, and the applicable.  §483.45(h) Storage §483.45(h)(1) In acceptable and the siologicals in locked temperature control personnel to have at \$483.45(h)(2) The foresidents as they are side of the side of th | dministering Medication dated, 119, directed PRN medication bllowed and made available to equested them. and Biologicals h)(1)(2)  g of Drugs and Biologicals als used in the facility must be ace with currently accepted ales, and include the ory and cautionary a expiration date when a of Drugs and Biologicals cordance with State and acility must store all drugs and discompartments under proper ls, and permit only authorized | F 7                 | 97  |        | 9/21/21                    |
|  | the Comprehensive   | d drugs listed in Schedule II of<br>Drug Abuse Prevention and<br>and other drugs subject to  |                     |   |        |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   |  | (X2) MULTIPLE CONSTRUCTION A. BUILDING  |  | (X3) DATE SURVEY<br>COMPLETED   |                            |
|--|---|--|---|--|---|----------------------------|
|  |   | 245578   | B. WING   |  |   | C<br><b>23/2021</b>        |
|  | PROVIDER OR SUPPLIER  |  | STREET ADDRESS, CITY, STATE, ZIP 2309 HAYES STREET NORTHEAS MINNEAPOLIS, MN 55418 |  | CODE  |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)  | N SHOULD BE   | (X5)<br>COMPLETION<br>DATE |
| F 761  | abuse, except whe package drug distriction quantity stored is in be readily detected. This REQUIREME by: Based on observative review, the facility medication room doucked to prevent in medications that within the potent and floor.  Findings include:  On 8/23/21, at 8:28 door on the 2nd floor on the 2nd floor station was observed present to monitor.  On 8/23/21, at 10:3 door on the 2nd flow without staff members door.  On 8/23/21, at 11:2 door on the 2nd flow without staff members door.  On 8/23/21, at 11:4 nursing (ADON) was tated narcotics we room and only in mistated other medication room, i medications. The American package of the state of the medications. The American package of the | in the facility uses single unit ibution systems in which the ninimal and a missing dose can l.  NT is not met as evidenced tion, interview, and document failed to ensure that the oor remained closed and esidents from having access to ere in the medication room. tial to affect all residents on the sa.m. the medication room for located next to the nursing ed to be open. Staff were not | F 7   | Second floor medication robeen secured. Signage had on keeping medication dood Licensed staff educated on room door closed at all time Supervision of Resident Poreviewed by LNHA and DO secured medication room of completed weekly for one rompliance results will be QAPI committee for recommittee for recommittees. | s been placed or closed. I medication es. Safety and plicy has been N. Audits of door will be month. Submitted to |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  |  | IPLE CONSTRUCTION NG | CON  | (X3) DATE SURVEY<br>COMPLETED |                            |
|--|--|--|----------------------|--|-------------------------------|----------------------------|
|  |  | 245578   | B. WING _            |  |                               | C<br>/ <b>23/2021</b>      |
|  | PROVIDER OR SUPPLIER   |  |                      | STREET ADDRESS, CITY, STATE, ZIP COI<br>2309 HAYES STREET NORTHEAST<br>MINNEAPOLIS, MN 55418 |                               | 20/2021                    |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)             | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)     | HOULD BE                      | (X5)<br>COMPLETION<br>DATE |
| F 761  | locked at all times.  The facility policy A revised 4/19/21, lac | ge 6  dministering Medications sked direction on locking the por when no staff were in the | F 76                 | 51   |                               |                            |



Protecting, Maintaining and Improving the Health of All Minnesotans

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 <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 <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html</a>. 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

Twin City Gardens September 10, 2021 Page 2

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

Minnesota Department of Health

Kumalu Fiske Downing

Program Assurance Unit

Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us

PRINTED: 09/15/2021 FORM APPROVED

Minnesota Department of Health

|                          | IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                     | E CONSTRUCTION   | (X3) DATE<br>COMP | SURVEY<br>LETED          |
|--------------------------|--|--|-------------------------|--|-------------------|--------------------------|
|                          |  |  | A. BOILDING.            |  |                   |                          |
|                          |  | 00167  | B. WING                 |  | 1                 | 3/2021                   |
| NAME OF F                | PROVIDER OR SUPPLIER   | STREET AD  | DRESS, CITY, S          | STATE, ZIP CODE  |                   |                          |
| TWIN CI                  | TY GARDENS   |  | ES STREET<br>OLIS, MN 5 | NORTHEAST<br>5418  |                   |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | _D BE             | (X5)<br>COMPLETE<br>DATE |
| 2 000                    | Initial Comments   |  | 2 000                   |  |                   |                          |
|                          | ****ATTE   | NTION*****   |                         |  |                   |                          |
|                          | NH LICENSING   | CORRECTION ORDER   |                         |  |                   |                          |
|                          | 144A.10, this correpursuant to a surver found that the deficion herein are not corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the number and MN Ruwhen a rule contain comply with any of lack of compliance. re-inspection with a result in the assess | hether a violation has been  |                         |  |                   |                          |
|                          | that may result from<br>orders provided that<br>the Department wit   | hearing on any assessments<br>n non-compliance with these<br>it a written request is made to<br>hin 15 days of receipt of a<br>ent for non-compliance.   |                         |  |                   |                          |
|                          | your facility by surv<br>Department of Hea<br>found NOT in comp<br>Licensure. Please i<br>of correction you ha   | rS: blaint survey was conducted at eyors from the Minnesota lth (MDH). Your facility was bliance with the MN State and cate in your electronic plan ave reviewed these orders and en they will be completed. |                         |  |                   |                          |

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

**Electronically Signed** 09/15/21

STATE FORM 6899 If continuation sheet 1 of 9 T6Q511

TITLE

(X6) DATE

|                          | IT OF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA   | ' '                     | E CONSTRUCTION   | (X3) DATE | SURVEY<br>LETED          |
|--------------------------|---|---|-------------------------|--|-----------|--------------------------|
| 74401044                 | OF CONTRECTION  | IDENTIFICATION NONDER.  | A. BUILDING:            |  |           |                          |
|                          |   | 00167   | B. WING                 |  | 08/2      | 23/2021                  |
| NAME OF                  | PROVIDER OR SUPPLIER  | STREET AD   | DRESS, CITY, S          | STATE, ZIP CODE  |           |                          |
| TWIN CI                  | TY GARDENS  |   | ES STREET<br>OLIS, MN 5 | NORTHEAST<br>5418  |           |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE     | (X5)<br>COMPLETE<br>DATE |
| 2 000                    | Continued From pa   | ge 1  | 2 000                   |  |           |                          |
|                          | The following comp SUBSTANTIATED: H5578056C (MN75 issued at 0830. H5578055C (MN75 order will be issued H5578053C (MN75 issued at 0830. An unrelated licens 1610. The Minnesota Dep documenting the Storders using Feder have been assigned statutes/rules for N tag number appear "ID Prefix Tag." The compliance is listed of Deficiencies" col Comply" portion of column also include violation of the state "This Rule is not me the surveyor's find Method of Correction. You have agreed to receipt of State lice the Minnesota Dep Informational Bullet <a href="https://www.healthon/infobulletins/ib14">https://www.healthon/infobulletins/ib14</a> orders are delineate Department of Hea you electronically, is necessary for Sta | plaint was found to be 1777) A licensing order will be 1675) A licensing order will be 1675) A licensing order will be 16326, MN75373) A licensing 1675) A licensing order will be 16975) A licensing order will be 16975) A licensing order will be 1798 artment of Health is 1798 tate Licensing Correction 1799 real software. Tag numbers 1799 de to Minnesota state 1799 ursing Homes. The assigned 1891 in the far-left column entitled 1891 es tate statute/rule out of 1991 in the "Summary Statement 1992 ursing Homes the "To 1992 the correction order. This 1993 es the findings which are in 1993 es the findings which are in 1994 es tatute after the statement, 1994 et as evidence by." Following 1994 lings are the Suggested 1995 or and Time Period for 1995 orders consistent with |                         |  |           |                          |

Minnesota Department of Health

STATE FORM 6899 T6Q511 If continuation sheet 2 of 9

|                          | IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ,                     | E CONSTRUCTION  | (X3) DATE<br>COMP | SURVEY<br>LETED          |
|--------------------------|--|--|-------------------------|---|-------------------|--------------------------|
|                          |  |  | A. BOILDING.            |   |                   |                          |
|                          |  | 00167  | B. WING                 |   | 08/2              | 3/2021                   |
| NAME OF I                | PROVIDER OR SUPPLIER   |  |                         | STATE, ZIP CODE   |                   |                          |
| TWIN CI                  | TY GARDENS   |  | ES STREET<br>OLIS, MN 5 | NORTHEAST<br>5418   |                   |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | D BE              | (X5)<br>COMPLETE<br>DATE |
| 2 000                    | Continued From pa  | ge 2   | 2 000                   |   |                   |                          |
|                          | electronic State lice<br>heading completion<br>be corrected prior to<br>the Minnesota Depa<br>is enrolled in ePOC  | ou must then indicate in the ensure process, under the date, the date your orders will be electronically submitting to eartment of Health. The facility and therefore a signature is pottom of the first page of   |                         |   |                   |                          |
|                          | FOURTH COLUMN<br>"PROVIDER'S PLA<br>APPLIES TO FEDE  | RD THE HEADING OF THE WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE.   |                         |   |                   |                          |
| 2 830                    | MN Rule 4658.0520<br>Proper Nursing Car  | O Subp. 1 Adequate and<br>re; General  | 2 830                   |   |                   | 9/21/21                  |
|                          | receive nursing carcustodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the | general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ang home resident must be out possible unless there is a he attending physician that the in in bed or the resident |                         |   |                   |                          |
|                          | by:<br>Based on observati<br>review, the facility fa   | ent is not met as evidenced on, interview, and document ailed to ensure adequate pain of 1 residents (R1) reviewed ent.  |                         | Corrected   |                   |                          |

Minnesota Department of Health

STATE FORM 6899 T6Q511 If continuation sheet 3 of 9

| STATEMEN                 | IT OF DEFICIENCIES OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                     | E CONSTRUCTION  | (X3) DATE<br>COMP | SURVEY<br>LETED          |
|--------------------------|--|--|---------------------|---|-------------------|--------------------------|
|                          |  | 00467  |                     |   | 00/2              |                          |
|                          |  | 00167  |                     |   | 08/2              | 3/2021                   |
| NAME OF I                | PROVIDER OR SUPPLIER   |  |                     | STATE, ZIP CODE<br>NORTHEAST  |                   |                          |
| TWIN CI                  | TY GARDENS   |  | OLIS, MN 5          |   |                   |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROI<br>DEFICIENCY) | D BE              | (X5)<br>COMPLETE<br>DATE |
| 2 830                    | Continued From pa  | ge 3   | 2 830               |   |                   |                          |
|                          | Finding include:   |  |                     |   |                   |                          |
|                          | diagnoses which in   | inted 8/23/21, indicated cluded atrial fibrillation ), osteoporosis, obesity, and  |                     |   |                   |                          |
|                          | 6/11/21, indicated F   | Im Data Set (MDS) dated<br>R1 was cognitvly intact, and<br>and required a high level of<br>to his wheel chair.   |                     |   |                   |                          |
|                          | pain management in (PRN) oxycodone in milligrams every six 10mg extended releascheduled every nix medication was bei                 | ers, dated 8/10/21, stated that medication for 'as needed' acl pain medication 5 to hours and an oxycontine ease (ER) 12 hours tablet ght at bedtime. The paining used for chronic back painer oral surgery with teeth                 |                     |   |                   |                          |
|                          | the facility, indicate<br>free of any discomf<br>from pain medicatio<br>also indicated, "Adr<br>medications as ord                   | ed 8/5/21 upon readmission to es that, "the resident will be ort or adverse side effects on through the review date." It minister ANALGESIC ered by physician. side effects and effectiveness  |                     |   |                   |                          |
|                          | stated his pain was<br>and the facility faile<br>medication as he had<br>was ordered. R1 samedication every si<br>two times per day. | a.m. R1 was interviewed and not being properly managed, d to provide him with his pain ad requested and as it was aid he was allowed to have the x hours, but usually only got it R1 stated it would often take ours give him his pain |                     |   |                   |                          |

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| 00167 B. WING 08/23/202*   | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:   |  |             | (X3) DATE SURVEY<br>COMPLETED                   |             |                          |
|--|--|--|--|--|-------------|---|-------------|--------------------------|
| NAME OF DROWINGS OR SURDIUGE   |  | 00167  |  | 00167  | B. WING     |   |             | _                        |
| TWIN CITY GARDENS 2309 HAYES STREET NORTHEAST  | AME OF PROVIDER OR SUI   | :NS 2309 H   |  | 2309 HAYE  | S STREET    | NORTHEAST                                       |             |                          |
| MINNEAPOLIS, MN 55418  |  | MINNEA   |  | MINNEAPC   | JLIS, WIN 5 | 5418  |             | 1                        |
| PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP   | PREFIX (EACH DEF   | H DEFICIENCY MUST BE PRECEDED BY FULL  |  | Y MUST BE PRECEDED BY FULL   | PREFIX      | (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE | N SHOULD BE | (X5)<br>COMPLETE<br>DATE |
| 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 1:2:00 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 | medication at had only gott past 24 hours showing any verbalize he was able to get hit TMA-A stated more frequer TMA-A stated multiple times practitioner (I On 8/23/21, at (RN)-A was in always asking stated R1 concevery six hours more frequer On 8/23/21, at nursing (ADC had PRN pain management pain medicat have it. The AR1 to a pain and done to help on 8/23/21, at was interview pain and requisitated R1 had recently to fig due to his his on 8/23/21, at a consequence of the pain and requisitated R1 had recently to fig due to his his on 8/23/21, at a consequence of the pain and requisitated R1 had recently to fig due to his his on 8/23/21, at a consequence of the pain and requisitated R1 had recently to fig due to his his on 8/23/21, at a consequence of the part of the pain and requisitated R1 had recently to fig due to his his on 8/23/21, at a consequence of the pain and requisitated R1 had recently to fig due to his his on 8/23/21, at a consequence of the pain and requisitated R1 had recently to fig due to his his on 8/23/21, at a consequence of the pain and requisitated R1 had recently to fig due to his his on 8/23/21, at a consequence of the pain and requisitated R1 had recently to fig due to his his on 8/23/21, at a consequence of the pain and requisitated R1 had recently to fig due to his his on 8/23/21, at a consequence of the pain and requisitated R1 had recently to fig due to his his on 8/23/21, at a consequence of the pain and requisitated R1 had recently to fig due to his his on 8/23/21, at a consequence of the pain and requisitated R1 had recently to fig due to his his on 8/23/21, at a consequence of the pain and requisitated R1 had recently to fig due to his his on 8/23/21, at a consequence of the pain and t | on after he requested it. R1 stated he gotten his pain medication twice in the nours. During the interview, R1 was not any signs or symptoms of pain, but did he was experiencing pain.  21, at 11:16 a.m. trained medication aid was interviewed. TMA-A stated R1 was et his pain medication every six hours. tated R1 asked for his pain medication quently than he was allowed to have it. tated R1 had been talked to about this times by nursing staff and his nurse her (NP)-A.  21, at 11:32 a.m. registered nurse was interviewed and stated R1 was sking for his pain medication. RN-A 1 could only have his pain medication is hours, however, he would ask for it quently than he was allowed.  21, at 11:43 a.m. the assistant director of ADON) was interviewed and stated R1 pain medication for pain ment. The ADON stated R1 wanted the dication more than he was allowed to the ADON stated R1's NP had referred being linic to figure out what could be help with his pain management.  21, at 12:00 p.m. social worker (SW)-A reviewed and stated R1 complained of requested pain medication often. SW-A reviewed and referred to a pain clinic to figure out how to best manage his pairs history of opioid abuse. | dical online dical | e requested it. R1 stated he pain medication twice in the ing the interview, R1 was not or symptoms of pain, but did experiencing pain.  16 a.m. trained medication aide viewed. TMA-A stated R1 was a medication every six hours. In the was allowed to have it. In the was allowed to have it. In the was allowed to about this the was allowed and stated R1 was allowed and stated R1 was allowed.  18 a.m. registered nurse ewed and stated R1 was allowed.  19 a.m. the assistant director of the was allowed.  19 a.m. the assistant director of the was allowed to stated R1 wanted the was allowed to stated R1's NP had referred to figure out what could be its pain management.  19 p.m. social worker (SW)-A and stated R1 complained of the pain medication often. SW-A and stated R1 complained of the pain medication often. SW-A and referred to a pain clinic the was pain in fopioid abuse. | 2 830       |   |             |                          |

Minnesota Department of Health STATE FORM

STATE FORM 6899 T6Q511 If continuation sheet 5 of 9

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |                     |  |                                   | X3) DATE SURVEY<br>COMPLETED |  |
|--|--|---|---------------------|--|-----------------------------------|------------------------------|--|
| ,  |  |   | A. BUILDING:        |  |                                   |                              |  |
|  |  | 00167   | B. WING             |  |                                   | C<br><b>23/2021</b>          |  |
| NAME OF PROVIDER OR  | SUPPLIER   | STREET AD   | DRESS, CITY, S      | STATE, ZIP CODE  |                                   |                              |  |
| TWIN CITY GARDENS 2309 HAYES STREET NORTHEAST MINNEAPOLIS, MN 55418  |  |   |                     |  |                                   |                              |  |
| PREFIX (EACH   | DEFICIENC'   | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETE<br>DATE     |  |
| comfortabe The DON have a mathis was so DON was should har medication followed the R1 was germedication DON reviewed record (Magetting parequested not been gas prescrious R1's order every 24 has 22/21, in doses:  8/10/21, oas/11/21, to 8/11/21, to 8/11/21, to 8/15/21, oas/16/21, oas/16/21, oas/17/21, zas/18/21, to 8/19/21, to 8/19/21, to 8/19/21, to 8/19/21, to 8/20/21, to 8/21/21, to 8/22/21, to 8/ | get him to the prescription of the prescriptio | to a pain clinic, and was not libing more pain medication. The pain clinic requested R1 resonance imaging (MRI), and for 9/1/21. At 2:47 p.m. the red angain and stated R1 reallowed to get his pain reduced every so long as it libed orders. The DON stated of the doses of oxycodone pain rested every six hours. The restricted every six hours. The restricted every six hours at libed or as the DON then stated R1 had a sallowed doses of oxycodone recodone allowed for 4 doses resonant was made at late and received the following research. | 2 830               |  |                                   |                              |  |

Minnesota Department of Health

STATE FORM 6899 T6Q511 If continuation sheet 6 of 9

| STATEMENT OF DEFICIENCIES  |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | , ,                 | E CONSTRUCTION  |           | DATE SURVEY              |  |  |
|--|--|--|---------------------|---|-----------|--------------------------|--|--|
| AND PLAN OF CORRECTION   |  | IDENTIFICATION NOWBER.   | A. BUILDING:        | <del></del>   | COMPLETED |                          |  |  |
|  |  | 00167  | B. WING             |   | 08/2      | 3/ <b>2021</b>           |  |  |
| NAME OF F  | NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE   |  |                     |   |           |                          |  |  |
| TWIN CITY GARDENS  2309 HAYES STREET NORTHEAST MINNEAPOLIS, MN 55418 |  |  |                     |   |           |                          |  |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROPERTION OF T | D BE      | (X5)<br>COMPLETE<br>DATE |  |  |
| 2 830  | Continued From page 6  |  | 2 830               |   |           |                          |  |  |
|  | residents as they re   | equested them.   |                     |   |           |                          |  |  |
|  | director of nursing (<br>develop, review, an<br>procedures that add  | THOD OF CORRECTION: The DON) or designee could d/or revise policies and dresses following provider ed' medication for pain   |                     |   |           |                          |  |  |
|  |  | ee could educate all<br>the policies and procedures<br>medication use.   |                     |   |           |                          |  |  |
|  |  | ee could develop monitoring ongoing compliance.  |                     |   |           |                          |  |  |
|  | TIME PERIOD FOR (21) days.   | R CORRECTION: Twenty-one   |                     |   |           |                          |  |  |
| 21610  | MN Rule 4658.1340<br>and Preparation Are   | O Subp. 1 Medicine Cabinet<br>ea;Storage   | 21610               |   |           | 9/21/21                  |  |  |
|  | must store all drugs<br>under proper tempe   | of drugs. A nursing home in locked compartments erature controls, and permit sing personnel to have  |                     |   |           |                          |  |  |
|  | by: Based on observati review, the facility fa medication room do locked to prevent re medications that we | ent is not met as evidenced on, interview, and document ailed to ensure that the por remained closed and esidents from having access to ere in the medication room. ial to affect all residents on the |                     | Corrected   |           |                          |  |  |
|  |  |  |                     |   |           |                          |  |  |

Minnesota Department of Health

STATE FORM 6899 T6Q511 If continuation sheet 7 of 9

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |   |             | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--|--|--|---|-------------|-------------------------------|--|
|   |  | 00167  | B. WING                                  |   |             | C<br><b>23/2021</b>           |  |
|   | NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  2309 HAYES STREET NORTHEAST   |  |  |   |             |                               |  |
|   | - GARBERO  | MINNEAF  | POLIS, MN 5                              | 5418  |             |                               |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                      | PROVIDER'S PLAN OF COI<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | I SHOULD BE | (X5)<br>COMPLETE<br>DATE      |  |
| 21610   | Continued From page 7  |  | 21610                                    |   |             |                               |  |
|   | 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. |  |  |   |             |                               |  |
|   |  |  |  |   |             |                               |  |
|   | nursing (ADON) was tated narcotics we room and only in mostated other medical medication room, in medications. The A   | 3 a.m. the assistant director of as interviewed. the ADON re not stored in the medication edication carts. The ADON ations would be stored in the including insulin and stock DON stated she would expect in door be kept closed and |  |   |             |                               |  |
|   | revised 4/19/21, lac   | dministering Medications<br>ked direction on locking the<br>oor when no staff were in the  |  |   |             |                               |  |
|   | director of nursing (<br>develop, review, an   | THOD OF CORRECTION: The (DON) or designee could d/or revise policies and dress medication room e expectations.   |  |   |             |                               |  |
|   | appropriate staff on   | ee could educate all<br>the policies and procedures<br>a security and storage  |  |   |             |                               |  |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                  |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                 | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |   | (X3) DATE<br>COMP | (X3) DATE SURVEY<br>COMPLETED |  |
|--|--|--|--|---|-------------------|-------------------------------|--|
|  |  | 00167  | B. WING                                  |   | 08/2              | 23/2021                       |  |
| NAME OF  | NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE                |  |  |   |                   |                               |  |
| TWIN CITY GARDENS  2309 HAYES STREET NORTHEAST MINNEAPOLIS, MN 55418 |  |  |  |   |                   |                               |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>'MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG                      | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE           | (X5)<br>COMPLETE<br>DATE      |  |
| 21610  | Continued From pa  | ge 8   | 21610                                    |   |                   |                               |  |
|  | expections.  |  |  |   |                   |                               |  |
|  | The DON or designee could develop monitoring systems to ensure ongoing compliance. |  |  |   |                   |                               |  |
|  | TIME PERIOD FOR CORRECTION: Twenty-one (21) days.                                  |  |  |   |                   |                               |  |
|  |  |  |  |   |                   |                               |  |
|  |  |  |  |   |                   |                               |  |
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|  |  |  |  |   |                   |                               |  |

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