DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 1, 2022

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

RE: CCN: 245298
Cycle Start Date: April 7, 2022

Dear Administrator:

On April 29, 2022, we notified you a remedy was imposed. On May 19, 2022 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of May 14, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective May 29, 2022 did not go into effect. (42 CFR 488.417 (b))

In our letter of April 29, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 5, 2022 due to denial of payment for new admissions. Since your facility attained substantial compliance on May 14, 2022, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health

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

Electronically delivered
April 29, 2022

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

RE: CCN: 245298
Cycle Start Date: April 7, 2022

Dear Administrator:

On April 7, 2022, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective May 29, 2022.

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

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 29, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 29, 2022.

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

new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by May 29, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, The Estates At Twin Rivers Llc will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 29, 2022. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

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

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same

deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - 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 October 7, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

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

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

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

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

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

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

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

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag) i.e., the plan of correction, request for waivers, should be directed to:

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245298	A. BUILDING _____ B. WING _____	C 04/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT TWIN RIVERS LLC	305 FREMONT STREET ANOKA, MN 55303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On April 4th -7th, 2022, a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1)	E 041		5/14/22

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

Electronically Signed | 05/09/2022

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E 041	Continued From page 1 Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records	E 041		

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E 041	Continued From page 2 Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect the generator per NFPA 101 (2012	E 041	A load bank test on the facility's generator has been scheduled to be completed on May 13th, 2022, with Hunt Electric	

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E 041	Continued From page 3 edition), Life Safety Code, section 9.1.3.1, NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.4, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.1 through 8.4.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1) On 04/06/2022 at 09:00 AM, it was revealed by a review of available documentation of the emergency generator maintenance and testing weekly generator tests were not performed between 08/10/21 and 08/26/2021 . 2) On 04/06/2022 at 09:00 AM, it was revealed by a review of available documentation of the emergency generator maintenance and testing an annual load bank test was not completed in the last 12 months because the generator did not reach 30%. An interview with Maintenance Director, Administrator and Regional Maintenance Director verified these deficient findings at the time of discovery.	E 041	Corporation. All residents who reside in the facility have the potential to be affected. The policy and procedure for the emergency generator has been reviewed and remains current. Education to Maintenance Director/staff regarding emergency generator has been completed. Maintenance Director/Designee is responsible for ensuring compliance.	
F 000	INITIAL COMMENTS On April 4th-7th, 2022, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. 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:	F 000		

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F 000	Continued From page 4 H5298134C (MN00077188), however NO deficiencies were cited due to actions implemented by the facility prior to survey: The following complaints were found to be UNSUBSTANTIATED: H5298135C (MN00079295) H5298136C (MN00081089) 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 substantial compliance with the regulations has been attained.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's	F 550		5/14/22

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F 550	Continued From page 5 individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure residents were dressed appropriately to preserve dignity for 1 residents (R87) who was observed in hospital gowns. Findings include: R87's entry Minimum Data Set (MDS) dated 3/27/22, identified resident was admitted to the	F 550	R87 was offered and provided assistance with dressing. R87's plan of care and nursing assistant sheet has been reviewed and revised as necessary. Refusals of care and/or preference changes related to dressing for R87 will be documented per policy. All residents have the potential to be exposed when in a hospital gown or clothing that is not appropriately fitted.	

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F 550	Continued From page 6 facility on that date. The initial care plan was completed and reviewed with R87 on 3/29/22, and indicated R87 required staff assistance for dressing. R87's Progress Note of 4/1/22, indicated that the R87's BIMS (brief interview for mental status) was at a moderate level of cognitive impairment. On 4/4/22, at 3:03 p.m. R87 was observed to be sitting in her room, wearing a hospital gown which tied in the back. R87 stated she often got up and walked in the hallway. R87 stated she had a t-shirt to put on, however, identified she had sent their pants out to the wash and they had not yet been returned. R87 was unable to recall when clothing had been sent out to the wash. R87 commented she made sure to hold the back of the gown when walking in order to be covered. R87 indicated she would ask family member to bring in clothing, however, stated she had not had the chance yet to do so. R87 had no other clothing items available to her other than the t-shirt as her pants had not been returned. On 4/4/22, at 7:40 p.m. R87 was observed walking in the hallway, past her room and beyond the nurses station. R87 was observed grasping her gown in the mid-back, however, able to visualize the top of the incontinence brief above where the gown was grasped. During this observation, one was able to easily visualize the lower portion of the incontinence brief and upper thigh. R87 was observed to walk with a quick pace down the hallway. R87 passed both residents and staff with no intervention/guidance/or assistance to cover their back provided. R87 returned her room	F 550	Residents were interviewed to ensure they had an adequate amount of clothing. Residents who were not able to be interviewed had family contacted and/or an inventory was completed. Residents were interviewed regarding their clothing preference and/or family contacted. Residents will continue to be assessed for these specific preferences and needs upon admit/re-admit, care conferences, and as needed with individual care plans being updated accordingly. The policy and procedure related to resident dignity/exercise of rights was reviewed and remains current. Education has been initiated and remains ongoing for staff to ensure that residents' dignity is maintained per policy. Education has been initiated and remains ongoing for staff regarding resident clothing preferences. Visual audits of 4 residents will be completed weekly for 4 weeks, monthly for 2 months, and then the QAPI will review audit findings and make necessary recommendations specific to resident clothing inventory, resident clothing preferences and ensuring residents are not exposed. The Director of Nursing/designee is responsible for ensuring compliance.	

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F 550	Continued From page 7 independently. During observation on 4/06/22, at 12:27 p.m. R87 was observed to be walking up and down the hall near her room, and proceeded past the nurses station. During this time, R87 grasped the back of the gown mid-back. R87 was not approached/redirected, or assisted by staff as they passed in the hallway. On 4/7/22, at 11:05 a.m. housekeeping (HK-A) stated laundry was sent out of the facility for washing, and indicated they were unaware of R87 missing any clothing. HK-A stated hospital gowns were available for resident use and came in multiple sizes. HK-A stated the gowns provided adequate coverage, and had not seen any problems. HK-A went on to comment there was the potential for some residents to be uncomfortable wearing a gown. HK-A stated there was available clothing in a resource area for residents who needed additional clotting. On 4/7/22, at 11:44 a.m. licensed practical nurse (LPN)-B indicated R87 had been refusing assistance with cares. LPN-A stated R87 had been observed dressed in a hospital gown as she walked in the hallway near her room, as well as when going to the common bathroom area. LPN-B stated R87 lacked an adequate supply of clothing and they had informed licensed social worker (LSW) of the need for clothing, and pants had been obtained for R87 at that time. LPN-B was unsure if she had clothing currently. On 4/7/22, at 12:38 p.m. LSW stated they had observed R87 walking in the hallways in a hospital gown, however, stated they recalled R87 was also wearing a robe. LSW stated the family	F 550		

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F 550	Continued From page 8 member was going to bring clothing, however, stated the facility had also obtained additional items so clothing was available. LSW stated lack of clothing, and personal exposure with use of a hospital gowns was a dignity concern. LSW stated when this was observed, staff should have provided assistance to assure coverage. At 2:30 p.m. LSW stated they had checked R87's room and there was no clothing available, and LSW stated she had obtained additional clothing for R87 that afternoon. On 4/7/22, at 1:48 p.m. the director of nursing stated they had seen R87 walking in the hallway in a hospital gown and had not seen any exposure. DON stated personal exposure while wearing a gown walking in the hallway was a dignity issue, and identified the staff were to assure adequate clothing was available.	F 550		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.	F 582		5/14/22

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F 582	Continued From page 9 §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility lacked evidence the facility provided the Skilled Nursing Facility Advanced Beneficiary	F 582	R193 discharged from facility on 1/28/2022. Residents will be provided the Skilled	

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F 582	Continued From page 10 Notice (SNFABN; CMS-10055) and the Notice of Medicare Non-Coverage (CMS-10123) to 1 of 2 residents (R193) reviewed whose Medicare Part A coverage ended and then remained in the facility. Findings include: In a review of R193's Medicare A coverage documentation, provided by the facility, the records lacked evidence R193 nor his family were provided the Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN; CMS-10055) and the Notice of Medicare Non-Coverage (CMS-10123) when R193's Medicare A Skilled Care ended. A review of R193's progress notes documented only the following, dated 1/18/22: "[social worker] also reviewed with spouse that residents would have private charges when Medicare coverage ends." The record did not identify if R193's right to appeal the facility's decision to end Medicare covered services was provided or discussed. An attempt was made to contact R193 and/or family, however, no return call was received. In review of the survey worksheet provided to the facility (SNF Beneficiary Protection Notification Review CMS-20052) indicated R193 began his Medicare A stay on 11/30/21, and was discharged from coverage on 1/20/22. A review of R193's medical record indicated R193 remained in the facility from 1/20/22 through 1/28/22 (8 days), paying privately. In an interview on 4/05/22, at 2:13 p.m. the administrator (ADM) stated that the facility was unable to locate evidence that the Skilled	F 582	Nursing Facility Advanced Beneficiary Notice and Notice of Medicare Non-Coverage timely when coverage is ending. Education provided to the appropriate leadership on SNF ABN and NOMNC forms. Facility will audit 3 residents weekly for 4 weeks, monthly for 2 months and then the QAPI will review audit findings and make necessary recommendations specific to timely/appropriate coverage ending to resident/representative. The Administrator/designee is responsible for ensuring compliance.	

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F 582	Continued From page 11 Nursing Facility Advanced Beneficiary Notice (SNFABN; CMS-10055) and the Notice of Medicare Non-Coverage (CMS-10123) were provided to either the resident or family. ADM stated only the progress note from the social worker that R193's wife was called and informed of Medicare A coverage was ending. ADM stated the facility should have kept copies of the forms. During an interview on 4/07/22, at 11:29 a.m. registered nurse (RN)-A stated he was responsible for providing residents the Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN; CMS-10055) and the Notice of Medicare Non-Coverage (CMS-10123) prior to being discharged from Medicare A discharge of services. RN-A stated that he remembered providing the forms to family, and that the facility scans copies into the resident record once signed. RN-A stated the facility had a medical records staff person who was assigned to perform the scanning, however, that staff member was no longer employed with the facility. A request was made for a facility policy for providing Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN; CMS-10055) and the Notice of Medicare Non-Coverage (CMS-10123) to the resident and/or their family/guardian, but was not provided.	F 582		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-	F 757		5/14/22

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F 757	Continued From page 12 §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure physician notification of high blood sugar levels in accordance with physician orders for management of hyperglycemia and failed to assess, monitor, and re-evaluate for signs and symptoms of hyperglycemia for 1 of 2 residents (R7) reviewed for unnecessary medications. Findings include: R7's significant change in status Minimum Data Set (MDS) (a comprehensive assessment tool) of 1/6/22, indicated resident was cognitively intact and was able to communicate his needs, and understand information relayed by others. R7's medical diagnoses of diabetes (a disease affecting your bodies use, and production of insulin),	F 757	R7's parameter order was reviewed and revised by PCP. Notifications to MD when parameters are met for R7 will be documented per policy. All residents who have orders with parameters to update MD have the potential to be affected. A full-house audit has been initiated to identify residents who have orders with parameters to update MD. Each identified resident's plan of care and NAR guide were reviewed and updated as necessary. The policy and procedure for change in resident condition was reviewed and remains current. Education has been initiated and remains ongoing for all nursing staff to ensure procedure for change in resident condition is followed per policy. Audits of 3 residents will be completed	

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F 757	Continued From page 13 R7's care plan, initiated on 9/5/21, with a target goal date of 2/6/22, identified R7 had diabetes, and the goal was for R7 to be free from symptoms of hypoglycemia (low blood sugar) and hyperglycemia. The care plan directed staff to have fasting serum blood sugar [sic] as ordered by doctor. The care plan identified symptoms of hyperglycemia should be reported to the MD (medical doctor). The care plan included the symptoms which included increased thirst/appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, abdominal pain, Kussmaul breathing (a change in breathing pattern related to high blood sugar), acetone breath (smells fruity), stupor, and coma. On 4/04/22, at 5:42 p.m R7 shared concerns regarding their overall health, and identified his last hospitalization was approximately one week ago. R7 went on to share his blood sugars were frequently elevated, however, stated the doctor was not consistently notified when this happened. A review of the April medication administration record (MAR) identified R7 had the following orders: -Victoza Solution (A non-insulin medication used to decrease blood glucose levels) Pen-injector 18 mg/3 ml (Liraglutide) Resident was to receive 1.8 mg subcutaneously in the morning for diabetes. This order was started on 3/12/22. -NovoLOG (a fast acting insulin) FlexPen 100 unit/ml 10 units subcutaneously before meals related to diabetes. This order was initiated on 3/12/22. -Tresiba FlexTouch Solution (a long acting insulin-a product given to lower blood glucose [sugar] levels) Pen-injector 200 units(a dosing	F 757	weekly for 4 weeks, monthly for 2 months, and then QAPI will review audit findings and make necessary recommendations specific to physician notification if parameters are met. The Director of Nursing/designee is responsible for ensuring compliance.	

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F 757	Continued From page 14	F 757		

measurement)/milliliter (ml-a measurement). Resident was to receive 73 unit subcutaneously (an injection just under the skin) one time a day related to diabetes. This order was initiated on 3/26/22.

R7's March 2022, MAR staff were to monitor R7's blood glucose before meals and at bedtime and instructed staff to update the provider if readings were less than 75 or greater than 400 (order start date 3/11/22). A review of the glucose readings from 3/11/22-3/31/22 identified R7's glucose reading was greater than 400 at 7:00 a.m. on 3/23/22. The glucose was greater than 400 at the 11:00 a.m. glucose check on the following dates: 3/12/22, 3/18/22, 3/26/22, 3/27/22, 3/27/22, and 3/31/22, with ranges from 404-432. R7's glucose readings were greater than 400 at 4:45 p.m. on the following dates: 3/17/22, 3/24/21, and 3/25/22, with a range of 409 to 511. R7's glucose reading was greater than 400 on 3/26/22, with a glucose reading of 419.

A review of glucose readings from 4/1/22 - 4/4/22 identified R7's glucose was greater than 400 on the following dates/times: 4/3/22 at 11:00 a.m. reading was 410, and 4/4/22 at 7:00 a.m. reading was 470.

A review of the documentation on the MAR from both months lacked any indication of further assessment or follow through with repeat glucose checks on the date/time the elevated readings were identified.

A review of R7's record from 3/4/22 through 4/5/22 lacked evidence of physician notification related to glucose readings of greater than 400

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F 757	Continued From page 15 per physician order. The MAR's directed staff to monitor for signs of hypo/hyperglycemia; boxes with check marks identified the order as completed with no other information that would identify how monitoring was completed or if R7 had hypo/hyper glycemic symptoms. Additionally, the narrative notes also did not include assessments of over all signs and symptoms when R7's blood glucose was elevated, monitoring, follow-up, and/or additional interventions after the elevated blood sugars were identified. R7's physician visit note dated 3/23/22, identified reason for visit was to follow-up on labs related to a recent hospitalization (not related to diabetic management). The visit note identified his last A1C on 2/25/22 (a blood test which measures your average blood sugar levels over the past 3 months) was 9.6%. This was elevated from their previous reading of 8.0% on 7/22/21. A normal reading for this test is less than 5.7%. The visit note indicated R7's blood sugar range was 269-511, the note did not identify a time frame in which those blood sugars were collected. The note included problem focus diagnosis "7) E11.9 Type II diabetes mellitus without complications: A1c is elevating. He is diet non-compliant and also medication non-compliant at time [did not specify which medication and frequency of non-compliance]. Ongoing education. Increase Tresiba." A Regulatory Visit note of 4/2/22 indicated R7 was seen by the provider per the request of staff and for follow-up on labs. The note identified the same blood sugar ranges as aforementioned visit and problem focus diagnosis E11.9 was verbatim from the aforementioned note.	F 757		

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F 757	Continued From page 16 On 4/7/22, at 1:57 p.m. the director of nursing (DON) reviewed R7's orders and identified the orders directed to staff to notify the provider if R7's blood sugars were less than 75 or greater than 400. Upon review of the glucose results, DON identified there were multiple readings which exceeded this perimeter, and upon review of the Progress Notes, identified there was no evidence of notification of the provider. DON stated R7's elevated blood sugars would be a concern with hyperglycemia (elevated blood sugar) and the effects of elevated blood sugars. DON stated R7 has been educated regarding the importance of diet and medication and although he did not always follow the recommendations, the provider was to be notified as outlined in the orders. A facility policy for notification of provider related to change in condition was requested and was not received	F 757		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		5/14/22

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F 880	Continued From page 17 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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F 880	Continued From page 18 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop and implement a comprehensive infection control program to include a complete, documented analysis of collected data to help reduce the potential spread of infection(s) within the facility. These findings have the potential of all 36 residents within the facility. Findings include: On 4/5/22, information was provided as requested for the facility infection control program. The information included Resident Monthly Summary and Monthly Resident Infection Statistics for the period from 12/1/21 through 3/31/22. December 2021: A review of the December 2021 Monthly Resident Infection Statistics (RIS) document included eleven entries which accounted for infections present in nine different residents. The infections listing identified pneumonia in one resident, soft	F 880	The facility has developed and implemented a comprehensive infection control program to include a complete, documented analysis of collected data to help reduce the potential spread of infection(s). All residents have the potential to be affected for infections if the facility has not developed and implemented a comprehensive infection control program. The policy and procedure related to infection control and tracking have been reviewed and updated accordingly. The facility will audit daily for 1 week, weekly for 4 weeks, monthly for 2 months the infection control of the infection tracker and residents' trends and signs/symptoms of infections. Infection Preventionist review will be ongoing but will be audited by Administrator/designee. The Director of Nursing and appropriate	

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F 880	Continued From page 19 tissue/cellulitis (a bacterial skin infection that causes redness, swelling, and pain)/wound infection in eight residents, and UTI's (urinary tract infections-infection in any part of the urinary system) for two residents. The Infection Statistics document lacked consistent information regarding symptoms presented, start date of antibiotic therapy, organism identified, infection location, lab work completed with date and results, stop date of antibiotics/total number of days of therapy, and tracking information of resident room or unit. The Resident Monthly Summary for December of 2021 identified infection types as identified on the RIS document however, was inconsistent and did not account for all the infections that had been identified. The Summary accounted for only six skin infections instead of the eight identified on the RIS. The Analysis/Patterns section indicated chronic sinusitis (which was not identified on the RIS) for one resident and identified a referral would be sought for an appointment with the ENT (a specialist in ears-nose and throat) if the infection persisted. The Analysis/Pattern for skin/wound infections lacked a comprehensive analysis for potential causal factors and possible trends, rather the summary indicated the facility would continue with chronic wound prophylaxis (administration of medication on a preventative basis). The Quality Improvement Conclusions/Actions/Outcome section identified the facility continued to vaccinate and administer boosters for Covid-19, maintained implementation of hygiene standards and use of PPE (personal protective equipment), and review of Covid/colds in residents. The section did not include an assessment of the effectiveness of infection prevention strategies or interventions	F 880	leadership staff have been educated to the infection control policy/procedure specific to a complete, documented analysis of infection control. The Director of Nursing/Designee will be responsible party.	

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	245298	A. BUILDING _____ B. WING _____	C 04/07/2022

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F 880	Continued From page 20	F 880		

and did not identify how the facility was going to monitor their prevention programs for effectiveness.

January 2022:

A review of the January 2022 Monthly Resident Infection Statistics included ten entries for infections present which impacted nine different residents. The infections included soft tissue/cellulitis (a bacterial skin infection that causes redness, swelling, and pain)/wound for seven residents, and prophylactic treatment for three residents. The Infection Statistics did not identify any residents with Covid 19. The Infection Statistics document lacked consistent information regarding symptoms presented, start date of antibiotic therapy, organism identified, infection location, lab work completed with date and results, stop date of antibiotics/total number of days of therapy, and tracking information of resident room or unit.

The Resident Monthly Summary for January of 2022 identified the following types of infection; cellulitis/soft tissue/wound infections: seven residents, prophylactic antibiotic treatment: three residents. The summary indicated there was one resident with Covid 19, which was not consistent with the RIS document. Although the Analysis/Patterns section identified a decrease in overall infections, it also identified an increase in skin/soft tissue infections and classified those as ongoing infections. The document indicated there were no breeches in infection control, and the facility was able to prevent any further spread of Covid to staff or residents. The document identified ongoing implementation of current infection control processes, no additional

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F 880	Continued From page 21	F 880		

interventions, and did not identify how the facility was going to monitor their prevention programs for effectiveness.

February 2022:

A review of the February 2022 Monthly Resident Infection Statistics listed 13 entries for infections present in ten different residents. The infections identified included soft tissue/cellulitis/wound for seven residents, and prophylactic treatment for five residents. The Infection Statistics document lacked consistent information regarding symptoms presented, start date of antibiotic therapy, organism identified, infection location, lab work completed with date and results, stop date of antibiotics/total number of days of therapy, and tracking information of resident room or unit.

The Resident Monthly Summary for February of 2022 was not consistent was the RIS document. The summary identified 13 infections, which included the following types of infection; URI: one resident, UTI: two residents, other/stye: one resident, Clostridium difficile (an infection of the large intestine (colon) which causes severe diarrhea):one resident, cellulitis/soft tissue/wound: three residents, and prophylactic antibiotics use in five residents. The Analysis/Patterns section indicated C. Diff was identified and contained, with no signs or symptoms identified within the population. The summary identified the individual resident was to receive further testing due to chronic nature of the condition. The summary identified staff education to all staff regarding C. Diff. The summary did not include an assessment of the effectiveness of infection prevention strategies or interventions for

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F 880	Continued From page 22	F 880		

other infection types and did not identify how the facility was going to monitor their prevention programs for effectiveness.

March 2022:

A review of the March 2022 Monthly Resident Infection Statistics document listed ten entries for resident infections, which impacted a total of seven residents. The infections identified include; Soft tissue/cellulitis/wound: three residents, prophylactic treatment: five residents, gastrointestinal (GI-nausea, vomiting, diarrhea): one resident, and vaginosis (vaginal infection) in one resident. The Infection Statistics document lacked consistent information regarding symptoms presented, start date of antibiotic therapy, organism identified, infection location, lab work completed with date and results, stop date of antibiotics/total number of days of therapy, and tracking information of resident room or unit.

An untitled document, included with the February monthly summary, had entries for 3/1/2022 and 3/2/22, which included the use of prophylaxis antibiotics and diagnosis of aspiration pneumonia. This information was not included on the Monthly Resident Infection Statistics for the month of March.

Although provided, the Resident Monthly Summary for March of 2022 lacked any documentation or analysis and infection control prevention strategies and monitoring.

On 4/7/22, at 9:59 a.m. the director of nursing (DON) identified she managed the infection control program, and used the above listed

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F 880	Continued From page 23	F 880		

documents to track information and analyze infections. DON stated the summaries of the infection control patterns were documented within the Quality Assessment & Program Improvement meeting notes. A copy of only the information with analysis of the Infection Control program was requested. The information provided identified the following

-January 2022: A dashboard of cumulative infections with breakdown of resident specific symptoms, however, lacked identification of trending by specific infection type, facility interventions put into place, and additional education that was provided.
-February 2022: A review was completed of the information provided, the dates were outlined as being from 12/21 through 2/22, the bar graph information was dated 2020 and 2021, and lacked information for 2022. The information provided lacked identification of the resident who was Covid positive with a positive PCR test on 1/25/22. Although the Dashboard provided cumulative infections, the information did not break down to show trending by specific infection type, or interventions implemented.
-March 2022: The information outlined on the Clinical Outcome Dashboard: Infections, indicated this was reflective of 2021 and 2022, however, lacked any information from 2022. Additionally, the graph did not reflect infections by type, merely the number of infections.

During interview on 4/7/22, at 2:21 p.m. DON stated they were relatively new to the infection control position. Although the DON stated they had a good understanding of the overall process and appropriate implantation of interventions, however, acknowledged the process was not

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F 880	Continued From page 24 consistently documented and identified there was room for improvement. The DON stated the information documented should have reflected the analysis of the information, interventions implemented, and improvements indicated in the infection control process. The Infection Prevention and Control Program policy, identified as doc.[sic] 8/17, identified the mission of the infection prevention and control plan was to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The policy outlined the purpose of surveillance (close observation) tools was to recognize the occurrence of infections, record their number and frequency, detecting outbreaks and epidemics, monitoring for infections, and detecting any unusual pathogens (disease causing organisms) with infection control implications. The document further identified that important facets of infection prevention included identify possible infections and potential complications of existing infections, institute measures to avoid complications, and educating staff to ensure they follow the proper techniques and procedures.	F 880		
F 912 SS=B	Bedrooms Measure at Least 80 Sq Ft/Resident CFR(s): 483.90(e)(1)(ii) §483.90(e)(1)(ii) Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide 80 square feet of floor space per resident in 8 of 28 resident	F 912	Residents who reside in rooms 7, 17, 20, 21, 29, 35, 36 have the potential to be affected. Previous and current residents	5/14/22

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F 912	Continued From page 25 rooms (room#s 4, 7, 17, 20, 21, 29, 35 and 36) which affected 12 residents (R290, R10, R24, R33, R23, R27, R20, R12, R5, R28, R30 and R4) who currently resided in these rooms. Findings include: During the entrance conference at 1:05 p.m.. on 10/28/19, the facility administrator stated there had been no changes in resident room sizes, and there were waivers in place for room numbers: 4, 7, 17, 20, 21, 29, 35 and 36, which did not meet the required minimum square footage. The following double resident rooms did not meet the required minimum square footage per resident: Room 4 = 150 square feet, or 75 square feet per resident, (R188) Room 7 = 152.5 square feet, or 76.25 square feet per resident, (R13) Room 17 = 150 square feet, or 75 square feet per resident, (R14) Room 20 = 150 square feet, or 75 square feet per resident, (R6 and R15) Room 21 = 150 square feet, or 75 square feet per resident, (R19) Room 29 = 150 square feet, or 75 square feet per resident, (R16 and R23) Room 35 = 150 square feet, or 75 square feet per resident, (R87)	F 912	have expressed no concerns. Facility working on submitting waiver. The policy and procedure regarding bedroom size was reviewed and remains current. Facility will complete 4 resident interviews weekly for 4 weeks, then monthly for 3 months and PRN with review of frequency and results to QAPI to ensure residents have no concerns of their room size. Administrator/Designee will be responsible party.	

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F 912	Continued From page 26 Room 36 = 155 square feet, or 77.5 square feet per resident, (R9 and R10) Resident interviews: On 4/4/22, at 6:30 p.m. R188's (room 4) family stated they had plenty of room for things and expressed no concerns with limited size. On 4/4/22, at 8:00 a.m. R13 (room 7) stated stated that she has enough room while her bed is along the wall. However, should she get a roommate (the 2nd bed being a baritric bed) uncertian how that would be. On 4/5/22, at 9:41 a.m. R14 (room 17) stated she had no concerns regarding room size. On 4/6/22, at 9:10 a.m. R6 ans R15 (room 20) stated no concerns with the their room. On 4/6/222, at 9:30 a.m. R19 (room 21) stated she had no concerns regarding the size of the room. On 4/5/22, at 9:05 a.m. R16 and R23 (room 29) were interviewed. R16 and R23 identified they had no concerns with their room size. R16's side of the room had an open space to accomodate the space of his wheelchair, recliner, bedside table, and bed. The room lacked space to allow easy movement about the room. R23's personal space allowed for a walkway from the recliner to the other side of the room. R23's bedside table was placed at the foot of his bed and was observed to be piled with clothing. There was no room to access the closet without considerable effort moving the bedside table. R16 identified he	F 912		

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F 912	Continued From page 27 did not use the closet to store any personal items. On 4/5/22 at 3:35 p.m. R87 was interviewed in their room. R87 was only the resident in the room and has not had a roommate since their admission on 3/27/22. On 4/4/22, at 7:05 p.m. R9 was observed in their room. R9 gestured things were "OK" when asked how the room, and denied concerns. R10 expressed satisfaction with room and expressed no concerns. Staffing interviews: During interview on 4/06/22 at 12:21 p.m. nursing assistant (NA)-A and NA-B stated they work throughout the building. Both staff mentioned all the rooms are small, however, in the rooms identified, they do not have difficulty meeting the residents needs. During interview on 4/06/22, at 3:10 p.m. licensed practical nurse (LPN)-A stated the aides try to keep the rooms clutter free. While some of the rooms are smaller and several of the residents have a lot of personal items, staff are still able to provide care.	F 912		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 04/06/2022. At the time of this survey, The Estates at Twin Rivers was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/09/2022

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The Estates at Twin Rivers is a 1-story building with a partial basement was built in 1962 with an addition in 1977 and was determined to be of Type II(111) construction. The facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 50 beds and had a	K 000		

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K 000	Continued From page 2 census of 36 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation.	K 222		5/14/22

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K 222	Continued From page 3 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the proper operation of exit door locking device system per NFPA 101 (2012 edition), Life Safety Code, section 7.2.1.6.1.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 04/06/2022 between 10:30 AM and 12:30	K 222	Facility had company come out to adjust the exit door delayed egress. The facility has posted the proper signage on the door. All residents who reside in the facility have the potential to be affected. The policy and procedure for exits or means of egress has been reviewed and remains current. Education was initiated and remains ongoing for all staff related to egress and	

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K 222	Continued From page 4 AM, it was revealed by observation the exit doors on the North East and the South East resident wings did not open when tested within 15 seconds. 2. On 04/06/2022 between 10:30 AM and 12:30 AM, it was revealed by observation the exit doors on the North East and the South East resident wings the delayed egress doors did not have the proper signage stating, "Push until alarm sounds, door can be opened in 15 seconds.". An interview with Maintenance Director, Administrator, and Regional Maintenance Director verified these deficient findings at the time of discovery.	K 222	emergency preparedness. Audits will be completed to assess function and signage placement, weekly for 4 weeks, monthly for 2 months, and then the QAPI will review audit findings and make necessary recommendations. Maintenance Director/Designee is responsible for ensuring compliance.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of	K 918		5/14/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245298	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/06/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 918	Continued From page 5 stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect the generator per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.4, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.1 and 8.4.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1) On 04/06/2022 at 09:00 AM, it was revealed by a review of available documentation of the emergency generator maintenance and testing weekly generator inspections were not performed between 08/10/21 and 08/26/2021 . 2) On 04/06/2022 at 09:00 AM, it was revealed by a review of available documentation of the emergency generator maintenance and testing an annual load bank test was not completed in the	K 918	A load bank test on the facility's generator has been scheduled to be completed on May 13th, 2022, with Hunt Electric Corporation. All residents who reside in the facility have the potential to be affected. The policy and procedure for the emergency generator has been reviewed and remains current. Education to Maintenance Director/staff regarding emergency generator has been completed. Weekly visual generator inspection audits will be completed weekly for 4 weeks, monthly for 2 months, and then the QAPI will review audit findings and make necessary recommendations. Maintenance Director/Designee is responsible for ensuring compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245298	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/06/2022**

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K 918	Continued From page 6 last 12 months in lieu of the generator did not reach 30%. An interview with Maintenance Director, Administrator, and Regional Maintenance Director verified these deficient findings at the time of discovery.	K 918		