DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 18, 2020

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

RE: CCN: 245298
Cycle Start Date: July 23, 2020

Dear Administrator:

On August 11, 2020, we notified you a remedy was imposed. On September 14, 2020 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of August 13, 2020.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective September 10, 2020 did not go into effect. (42 CFR 488.417 (b))

In our letter of August 11, 2020, 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 10, 2020 due to denial of payment for new admissions. Since your facility attained substantial compliance on August 13, 2020, 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 Therefore, the NATCEP prohibition is rescinded.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,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

Electronically delivered
August 11, 2020

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

RE: CCN: 245298
Cycle Start Date: July 23, 2020

Dear Administrator:

On July 23, 2020, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 10, 2020.

- 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 September 10, 2020. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 10, 2020.

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 $10,483; 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 September 10, 2020, 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 September 10, 2020. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.
However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient

practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Susie Haben, Unit Supervisor
St. Cloud A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 West Division Street, Suite 212
St. Cloud, Minnesota 56301
Email: susie.haben@state.mn.us
Phone: 320-223-7356

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 January 23, 2021 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@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 07/23/2020

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
F 000	INITIAL COMMENTS On 7/22/20 thru7/23/20, an abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was not in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following complaints were found to be substantiated with no deficiencies. H5298091C H5298092C The following complaints were found to be unsubstantiated. H5298090C H5298093C H5298094C However, as a result of the investigation deficiencies were identified at F609 and F880 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. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4)	F 609		7/24/20

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

Electronically Signed | 08/20/2020

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

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F 609	Continued From page 1 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview and documentation review the facility failed to report allegation of verbal abuse to the state agency within 2 hours for 1 of 1 (R7) residents who alleged verbal abuse from staff. Findings include: Observation on 7/23/2020, at 9:14 a.m. R7 stated	F 609	R7 allegation of abuse was reported to appropriate State Agency on 7/23/2020. Regional Director of Operations immediately educated facility Administrator on timely reporting. Residents will remain free from abuse and neglect within the facility specifically to ensuring timely reporting to the State Agency.	

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F 609	Continued From page 2 to licensed practical nurse (LPN-A) during a transfer in the bathroom that, "one gal gets mad and yells at me if I don't help pull my pants down and up". LPN-A did not respond to R7's statement, but reminded R7 she should hold onto the grab bar and she would help her with her pants. During interview on 7/23/2020, at 9:41 a.m. R7 stated she doesn't know the name of the aide that yelled at her. R7 stated the nursing assistant worked with her yesterday (7/22/20). R7 stated the nursing assistant makes her feel like she doesn't know what she is doing and stated the aide yells and gets mad only when she is in the bathroom which involves pulling her pants up and down. R7 went on to say she doesn't know what she was supposed to do as she gets mad if she helps and then gets mad if she doesn't help. During interview on 7/23/2020, at 10:08 a.m. Administrator was notified of R7's allegation of verbal abuse from a staff member by surveyor. During interview on 7/23/20, at 10:17 a.m. Administrator stated she had talked with R7 and as part of their response, confirmed R7 stated the staff member was not here today. Administrator added, next time staff was here the facility would attempt to have R7 point out suspected employee to confirm identify as R7 was unable to provide the employee's name but did have a description and when she worked last. The administrator identified through her interview with R7, it was unclear if the employee was joking or not. During interview on 7/23/20, at 10:56 a.m. director of nursing (DON) stated policy for abuse states any reports of abuse verbal or physical	F 609	Administrator educated by Regional Director of Operations on 7/23/2020 regarding response time to completing OHFC on suspected abuse. Facility staff education regarding Monarch Healthcare Management Abuse Prohibition/Vulnerable Adult Plan initiated on 7/23/2020. Audit all OHFC reports weekly x 4, then monthly x2 to ensure timely submission. The results of these audits will be reviewed with the facility QAPI Committee for input on the need to increase, decrease or discontinue the audits Administrator or designee will be responsible party	

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F 609	Continued From page 3	F 609		

should be reported within 2 hours. DON stated verbal abuse should be reported to Office of Health Facility Complaints (OHFC). DON and administrator would investigate and decide to report or not report. Stated she had spoken with the administrator and the administrator was calling nursing assistant now in regards to the allegation that was made this morning. DON stated R7's story changed a little bit and was not sure if the aide said it to be funny or not. DON States with R7's story being different she is meeting with the administrator after the administrator talks with some of the nursing assistant. DON stated they look at history, what happen, what can they investigate in time frame (2 hours). They also have regional team involved and will meet with them as well to see if reportable or not.

During interview on 7/23/20, at 1:13 p.m. Licensed practical nurse (LPN)-A stated she reported the incident with R7 to the administrator within the hour of being notified of the allegation of abuse. LPN-A stated per policy they have 2 hours to report to state agency.

During interview on 7/23/20, at 1:19 p.m. Administrator stated she had spoke with the nursing assistant who reported her and R7 have a good relationship. Denied allegation of getting mad or yelling at R7. Administrator stated she knows they are over the 2 hour mark, but they have not determined if they are going to report this or not.

During interview on 7/23/20, at 1:41 p.m. Regional administrator stated she was just educating the administrator about the 2 hour reporting policy for abuse. Stated any abuse

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F 609	Continued From page 4 allegation needs to be reported within 2 hours. Regional administrator stated during the 2 hours they have the opportunity to question the VA and make sure that all residents are safe, but then should report to the state agency. Undated policy, Abuse Prohibition/Vulnerable Adult Plan states Suspected abuse shall be reported to OHFC online reporting process not later than 2 hours after forming the suspicion of abuse.	F 609		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual 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	F 880		8/13/20

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F 880	Continued From page 5	F 880		

procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its

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F 880	Continued From page 6 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff were being actively screened for signed and symptoms of COVID-19 (screened by another staff), upon entry to the facility. This had the potential to affect all 41 residents currently residing within the facility, as well as, all other facility staff and visitors. Findings include: Observation on 7/23/20, at 7:43 a.m. staff entered front door of facility, filled out questionnaire and then took own temperature then walked around roped barrier. No other staff members at door. During an interview on 7/23/20, at 7:45 a.m. certified occupational therapy assistant COTA-A stated she comes into work through main door, fills out COVID questions and takes own temperature and records it. Stated the nurse will look at the forms at some point. Denies being screened by other staff members. Observation on 7/23/20, at 7:45 a.m. staff member walked into the main entrance, fill out COVID questionnaire, took own temperature with touchless thermometer, and then walked around roped barrier. Observation on 7/23/20, at 7:47 a.m. staff member walked into the main entrance, filled out COVID questionnaire and took own temperature, recorded it, and the walked around roped barrier.	F 880	The facility has initiated active screening process of employees/vendors/outside individuals that enter the facility to ensure they are not self-screening. Residents will remain at a decreased risk of contracting COVID-19 within the facility. Staff education initiated on Monarch Health Care Management Coronavirus (COVID-19) policy specific to COVID-19 screening process and facility specific screening area. Staff education initiated on Monarch Health Care Management COVID-19 Screening Tool to ensure appropriate screening and form completion. Assigned staff will be provided competencies on Monarch Health Care Management temperature competencies on taking and recording temperature and will be able to identify safe temperature parameters and demonstrate knowledge of when to notify a nurse. Audits will be completed on all shifts, four times a week for one week, twice weekly for one week and biweekly thereafter, until 100% compliance is achieved to ensure active screening is being completed at the point of entry for all persons who enter the facility. The results of these audits will be reviewed with the facility QAPI Committee for input on the need to increase, decrease or discontinue the audits. Director of Nursing or designee will be responsible party	

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F 880	Continued From page 7	F 880		

During interview on 7/23/20, at 8:05 a.m. therapeutic recreation director (TRD), stated when she enters the building she grabs a COVID screening questionnaire, takes her own temperature, sanitizes thermometer and then sanitizes hands. Stated she has also self screened and the nurse will review if needed.

During interview on 7/23/20, at 8:23 a.m. trained medication aide (TMA)-A stated she comes into work grabs COVID screening questionnaire, fills it out and takes own temperature. Stated she thinks someone checks the forms but is not sure.

During interview on 7/23/20, at 9:50 a.m. nursing assistant (NA)-A stated "we take our own temperature, write it on the form and someone looks at the forms later".

During interview on 7/23/20, at 10:56 a.m. DON stated the process for coming into work is all staff enter main entrance, grab screening form, and wait at roped area for another staff member to take temperature and review COVID questions. Staff are not to be screening themselves. Stated she just bought a bell for people to ring if no staff members are at door and will be putting a sign at the door as well.

A facility Coronavirus police revised 7/2/20, identified The facility should screen at the beginning of their shift for fever and/or other symptoms of COVID-19 such as Chills, Shortness of Breath, New or Change in Cough, Sore Throat, Muscle Pain, Headache, New Loss of Taste or Smell, Nausea, Vomiting, or Diarrhea. Actively take their temperature and document absence of shortness of breath, new or change in cough, sore throat, and other

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 07/23/2020

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
F 880	Continued From page 8 symptoms of COVID-19.	F 880		

DIRECTED PLAN OF CORRECTION

A Directed Plan of Correction (DPOC) is imposed in accordance with 42 CFR § 488.424. Your facility must include the following in their POC for the deficient practice cited at F880:

Active Screening

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

POLICIES/PROCEDURES/SYSTEM CHANGES:

- The facility's Quality Assurance and Performance Improvement Committee must conduct a root cause analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence.

The Infection Preventionist and Director of Nursing, shall complete the following:

- Develop and implement procedures, policies, and forms regarding active screening for temperature and signs and symptoms of COVID-19, in accordance with CDC guidelines to be conducted at the point of entry for every person who enters the facility. The procedures and policy must restrict entrance to anyone who does not meet the criteria as outlined by the CDC. This procedure must include actively measuring and recording staff temperature and assessment of shortness of breath, new or changed cough, and sore throat. The results must be documented. The MDH COVID-19 Toolkit: has examples of forms to utilize for staff screening. Toolkithttps://www.health.state.mn.us/diseases/coronavirus/hcp/ltctoolkit.pdf

TRAINING/EDUCATION:

As part of a corrective action plan, the facility must provide training for Infection Preventionist and all other staff who enter the facility, as well as staff responsible for the screening. The training must cover the need for active screening. The CDC has training videos available for COVID-19 which may be utilized, Training for Healthcare Professionals; https://www.cdc.gov/coronavirus/2019-ncov/hcp/training.html and the MDH COVID-19 Toolkit may be utilized.

- Include documentation of the completed training with a timeline for completion.
- The training may be provided by the Director of Nursing, Infection Preventionist, or Medical Director with an attestation statement of completion.

CDC RESOURCES:

Infection Control Guidance: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html
CDC: Isolation Precautions Guideline:

https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007): https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Personal Protective Equipment: https://www.cdc.gov/niosh/ppe/
Healthcare Infection Prevention and Control FAQs for COVID-19:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-faq.html

MDH RESOURCES:
Personal Protective Equipment (PPE) for Infection Control:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/ppe/index.html
MDH Contingency Standards of Care for COVID-19: Personal Protective Equipment for Congregate Care Settings (PDF): https://www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf
Interim Guidance on Facemasks as a Source Control Measure (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/maskssource.pdf
Interim Guidance on Alternative Facemasks (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/masksalt.pdf
Aerosol-Generating Procedures and Patients with Suspected or Confirmed COVID-19 (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/aerosol.pdf
Droplet Precautions:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html
Airborne Precautions:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html

MONITORING/AUDITING:

- The Director of Nursing, the Infection Preventionist, and other facility leadership will conduct audits on all shifts, four times a week for one week, twice weekly for one week and biweekly thereafter, until 100% compliance is achieved to ensure active screening is being completed at the point of entry for all persons who enter the facility.

- The Director of Nursing, Infection Preventionist or designee will review the results of audits and monitoring with the Quality Assurance Program Improvement (QAPI) program.

In accordance with 42 CFR § 488.402(f), this remedy is effective 15 calendar days from the date of the enforcement letter. The DPOC may be completed before or after that date. The effective date is not deadline for completion of the DPOC. However, a revisit will not be approved prior to receipt of documentation confirming the DPOC was completed. To successfully complete the DPOC, the facility must provide all of the following documentation identified in the chart below. Documentation should be uploaded as attachments through ePOC.

Imposition of this DPOC does not replace the requirement that the facility must submit a complete POC for all cited deficiencies (including F880) within 10 days after receipt of the Form CMS 2567.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 11, 2020

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

Re: Event ID: O8B711

Dear Administrator:

The above facility survey was completed on July 23, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00866	A. BUILDING: _____ B. WING _____	C 07/23/2020

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THE ESTATES AT TWIN RIVERS LLC	305 FREMONT STREET ANOKA, MN 55303

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/22/20 thru7/23/20, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be in compliance with the MN State Licensure. The following complaints were found to be substantiated.	2 000		

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2 000	Continued From page 1 H5298091C H5298092C The following complaints were found to be unsubstantiated. H5298090C H5298093C H5298094C The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		