Electronically delivered
March 29, 2021

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

RE: CCN: 245298
Cycle Start Date: March 9, 2021

Dear Administrator:

On March 9, 2021, a survey was completed at your facility by the Minnesota Department(s) of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective April 13, 2021.

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

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by April 13, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, The Estates At Twin Rivers Llc will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 13, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

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

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.

- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Karen Aldinger, Unit Supervisor
Metro C District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 9, 2021 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C)

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,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

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 03/09/2021

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

(X4) ID PREFIX TAG	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 3/8/21 through 3/11/21, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found NOT to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5298107C (MN00070564). The following complaints were found to be UNSUBSTANTIATED: H5298108C (MN00070663) and H5298109C (MN00070744). 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 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 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and	F 686		3/15/21

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

Electronically Signed | 04/02/2021

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 03/09/2021

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

(X4) ID PREFIX TAG	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 686	Continued From page 1 (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide pressure ulcer care per physician orders, and notify the physician when they were unable to provide the ordered wound care for 1 of 2 residents (R2) reviewed who had pressure ulcers. This resulted in actual harm for R2 when the pressure ulcer deteriorated, became infected, and R2 was hospitalized for sepsis. Findings include: R2's 5 day PPS Minimum Data Set (MDS) dated 2/26/21, included cognitively intact, required extensive assistance with bed mobility, transfers and hygiene. R2 had 5 stage 4 pressure ulcers (Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling) and 1 unstageable pressure ulcer (Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar), which were all present upon admission. An admission MDS had not been completed. R2's Braden Scale (scale used to determine pressure ulcer risk) dated 2/20/21, identified risk factors of confined to bed, very limited mobility, friction and shear concern. R2 had diagnoses of paraplegic (paralysis of the legs and lower body), needed to be repositioned every 2 hours and had	F 686	TAG: The facility failed to provide pressure ulcer care per physician orders and notify the physician when they were unable to provide the ordered wound care for 1 of 2 residents (R2) reviewed who had pressure ulcers. This resulted in actual harm for R2 when the pressure ulcer deteriorated, became infected, and R2 was hospitalized for sepsis. Affected Residents: For R2 identified, the resident was sent out to the hospital and discharged directly from the facility 3/2/2021. The facility did contact the hospital to ensure appropriate information/report and follow up occurred. Residents at Risk: The facility completed a full house audit on 3/2/21 to determine if other residents in the building had skin impairments and or concerns. Follow up was completed that was needed. Policy and Procedures: Skin Assessment and Wound Management and Prevention of Pressure ulcers/Injuries were reviewed and no changes needed.	

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 03/09/2021

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

(X4) ID PREFIX TAG	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 686	Continued From page 2 a stage 4 pressure ulcer on right buttocks. R2's care plan dated 2/22/21, identified R2 as having an alteration in skin integrity, pressure ulcer to right iliac crest (the curved upper border of the ileum which is the largest of the three bones that form the hip bone), stage 4. Staff were directed to: Monitor skin integrity during cares. Weekly skin inspection by nurse. Treatment to open areas per order. Monitor for skin breakdown and for signs and symptoms of infection. Report signs and symptoms to MD (doctor) or physician assistant. Document on skin condition and keep MD/physician assistant informed. R2's Physician's orders for wound care dated 2/19/21, directed staff to, change right iliac crest dressing and perform wound care three times per week. Irrigate wound thoroughly with Microcyn (antimicrobial wound cleanser) wound cleanser. Pat dry. Paint intact skin surrounding wound with Cavilon- no sting barrier film. Cut wound vac (foam dressing in the wound bed connected to suction, to help aid in wound healing) foam dressing to fit wound and apply to wound bed. If bridging, (intact skin between open areas) be sure to apply drape to intact skin under the foam to protect skin from injury. Cover foam and bridge with vac drape to achieve seal. Set negative pressure at 125 mm Hg (millimeters of mercury/ a unit of pressure) continuous. Change on evening shift. R2's treatment administration record (TAR) for February 2021, showed no documentation from to ensure the wound vac was on and functioning properly every shift, from admission on 2/19/21, until the evening shift on 2/22/21, three days after	F 686	Education: Licensed nurses have completed Wound Management Education and Training. Which includes what to do if unable to complete a treatment as ordered and when to notify a provider/MD. Nursing department staff will be trained on prevention of pressure ulcers. Wound Management Education and Training has been initiated as of 3/5/21. Education of prevention of pressure ulcers education has been initiated as of 3/2/21. Licensed Nurses will complete wound vac competency prior to completing wound vac treatments. Audits: MD/Provider Communication Audit The DON and or appropriate designee to complete audits of skin treatments to ensure that the MD was notified of skin concerns per protocol; new wounds, worsening wounds, changes needed to dressing orders, dressings not available, signs and symptoms of infections. This audit will be completed 2 residents 3 times a week for four weeks, if successful it will be titrated to 2 residents weekly for 1 month. If successful, will review at QAPI/IDT at that time to determine if additional audits are needed. If successful it will be titrated to once weekly and then once monthly. If titration is successful, IDT will discuss and	

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 03/09/2021

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

(X4) ID PREFIX TAG	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 686	Continued From page 3 admission. No other treatment to the stage 4 pressure ulcer on R2's right iliac crest had been identified. R2's medical record did not identify if R2's provider had been notified the wound vac to right iliac crest had not been implemented. When interviewed via phone on 3/10/21, at 12:06 p.m. the Operations Supervisor (OS) at Northwestern Respiratory (company that supplies wound vac and supplies to the facility) stated the intake department received an order for a wound vac for R2 on 2/18/21, at 5:00 pm. The driver delivered the wound vac at 7:15 p.m. that same day. The driver was required to hand supplies to a nurse to sign for the delivery of the wound vac. When interviewed via phone on 3/10/21, at 2:51 p.m. licensed practical nurse (LPN)-B stated she worked the evening of 2/18/21, and remembered signing for a wound vac set up that was delivered to facility. LPN-B delivered it to the transitional care side of facility and placed the package on top of the counter at the nurses station. LPN-B had reported there was a delivery to, "someone," but could not remember who. LPN-B was not responsible for R2 that evening. R2's progress note dated 2/19/21, at 3:24 p.m. included, "Patient has many wounds on BLE [bilateral lower extremities] and one wound on right side of hip that a wound vac has been ordered for. Due to severe pain, wound on right hip was not measured and PM nurse was notified to measure when wound vac comes prior to placing on wound." When interviewed on 3/9/21, at 11:10 a.m. LPN-A stated she had admitted R2 on 2/19/21, and had measured all wounds except the one on her iliac	F 686	discontinue. Skin Treatment Audits Residents 'dressings and or treatments records will be audited to ensure that they are being completed per orders and proper follow up is occurring. The audits will be completed by the DON and or appropriate designee. The audits will be done on 2 residents 3x a week for 2 weeks. If after two weeks there is no concerns, titration will occur and go to 2 residents once a week and then 2 residents monthly. If titration is successful, IDT will discuss and discontinue. TAG: The facility failed to provide pressure ulcer care per physician orders and notify the physician when they were unable to provide the ordered wound care for 1 of 2 residents (R2) reviewed who had pressure ulcers. This resulted in actual harm for R2 when the pressure ulcer deteriorated, became infected, and R2 was hospitalized for sepsis. Affected Residents: For R2 identified, the resident was sent out to the hospital and discharged directly from the facility 3/2/2021. The facility did contact the hospital to ensure appropriate	

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 03/09/2021

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

(X4) ID PREFIX TAG	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 686	Continued From page 4 crest, as R2 was having too much pain. She passed the information on to the afternoon shift to complete when the wound vac arrived. LPN-A did not know the wound vac had been delivered on 2/18/21. R2's progress note dated 2/19/21, at 10:05 p.m. included, "New resident admitted to facility today. She c/o [complained of] excruciating pain all over body. Dressing did not get completed due to pain. Resident given PRN [per resident need or as needed] and scheduled pain medications that helped some, but not enough. Wound vac not delivered this shift." When interviewed via phone on 3/11/21, at 9:25 am, registered nurse (RN)-C stated she was working the evening R2 was admitted on 2/19/21. R2 was in so much pain when she got to the facility. RN-C stated she offered to do wound care, but R2 refused due to pain. RN-C stated the wound vac did not arrive on her shift. RN-C reported she did not notify the physician of the refusal of wound care or that the wound vac hadn't arrived. RN-C was not aware of any facility policy of when to notify the provider. RN-C was not aware the wound vac had been delivered on 2/18/21. R2's progress note dated 2/21/21, at 2:10 p.m. included, "Call placed to Northwest oxygen to find out status of wound vac ordered Friday. Order resent and wound vac to be delivered this pm." This was 2 days since R2 was admitted. There was no evidence in the medical record R2's provider had been contacted and orders obtained on how to manage the wound to her right iliac crest if the wound vac was not available.	F 686	information/report and follow up occurred. Residents at Risk: The facility completed a full house audit on 3/2/21 to determine if other residents in the building had skin impairments and or concerns. Follow up was completed that was needed. Policy and Procedures: Skin Assessment and Wound Management and Prevention of Pressure ulcers/Injuries were reviewed and no changes needed. Education: Licensed nurses have completed Wound Management Education and Training. Which includes what to do if unable to complete a treatment as ordered and when to notify a provider/MD. Nursing department staff will be trained on prevention of pressure ulcers. Wound Management Education and Training has been initiated as of 3/5/21. Education of prevention of pressure ulcers education has been initiated as of 3/2/21. Licensed Nurses will complete wound vac competency prior to completing wound vac treatments. Audits: MD/Provider Communication Audit The DON and or appropriate designee to complete audits of skin treatments to	

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 03/09/2021

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

(X4) ID PREFIX TAG	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 686	Continued From page 5 When interviewed via phone on 3/10/21, at 12:06 p.m. OS at Northwestern Respiratory stated, "The on-call service received a call 2/21/21, stating the facility had not received wound vac. Driver was unable to see in the database that a wound vac had already been delivered 2/18/21; therefore another wound vac was delivered 2/21/21. We then picked up the extra wound vac on Wednesday [2/24/21]." R2's progress note dated 2/22/21, at 1:36 p.m. included, wound vac "changed" this shift. When interviewed 3/10/21, 10:50 am, the writer of the note, RN-A, clarified, "The wound vac was started, not changed." This was 3 days after admission. When interviewed on 3/10/21, at 10:50 a.m. the assistant director of nursing (ADON), stated the wound vac was delivered 2/21/21 with the incorrect tubing. The ADON stated that the improper tubing delivery 2/21/21, "was likely the reason the wound vac wasn't started [2/21/21] once delivered." The ADON stated she was unsure what, if any, wound care had been done between 2/19/21 -2/22/21, when the wound vac wasn't being used. The ADON stated when there was an issue with the wound vac, the doctor should have been notified for an alternate treatment plan. However, R2's provider had not been notified and no wound care orders had been received. R2's Initial Wound Evaluation and Management Summary dated 2/23/21, from a wound physician MD-A, identified a stage 4 pressure ulcer to the right buttocks. The wound measured 8 cm (centimeters) by 5.8 cm by 3.1 cm. The wound contained undermining (occurs when the tissue	F 686	ensure that the MD was notified of skin concerns per protocol; new wounds, worsening wounds, changes needed to dressing orders, dressings not available, signs and symptoms of infections. This audit will be completed 2 residents 3 times a week for four weeks, if successful it will be titrated to 2 residents weekly for 1 month. If successful, will review at QAPI/IDT at that time to determine if additional audits are needed. If successful it will be titrated to once weekly and then once monthly. If titration is successful, IDT will discuss and discontinue. Skin Treatment Audits Residents 'dressings and or treatments records will be audited to ensure that they are being completed per orders and proper follow up is occurring. The audits will be completed by the DON and or appropriate designee. The audits will be done on 2 residents 3x a week for 2 weeks. If after two weeks there is no concerns, titration will occur and go to 2 residents once a week and then 2 residents monthly. If titration is successful, IDT will discuss and discontinue. Completion Date: 3/15/21	

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 03/09/2021

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

(X4) ID PREFIX TAG	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 686	Continued From page 6	F 686		

under the wound edges becomes eroded, resulting in a pocket beneath the skin at the wound's edge) present with measurements 2.5 cm at 1 o'clock (location of undermining in comparison to the time on a clock). Drainage was described as moderate sero-sanguineous (yellowish with small amounts of blood). Wound bed showed 100% granulation tissue (light red or pink in color, and moist. An indicator of healing).

R2's treatment administration record (TAR) for February 2021, identified R2 was to receive the physician ordered treatment to the right iliac 3 times per week on Tuesdays, Thursdays and Saturdays. The treatment ordered was: change right iliac crest dressing and perform wound care three times per week. Irrigate wound thoroughly with Microcyn (antimicrobial wound cleanser) wound cleanser. Pat dry. Paint intact skin surrounding wound with Cavilon- no sting barrier film. Cut wound vac (foam dressing in the wound bed connected to suction, to help aid in wound healing) foam dressing to fit wound and apply to wound bed. If bridging, (intact skin between open areas) be sure to apply drape to intact skin under the foam to protect skin from injury. Cover foam and bridge with vac drape to achieve seal. Set negative pressure at 125 mm Hg (millimeters of mercury/ a unit of pressure) continuous. The treatment was not signed out as being completed on Saturday 2/27/21, with the last treatment being identified on 2/25/21.

When interviewed via phone 3/11/21, at 10:52 a.m. registered nurse (RN)-B stated she worked the evening of 2/27/21, and was unable to complete scheduled wound care during her shift due to not enough time. RN-B reported to LPN-C that wound care to right iliac crest still needed to

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 03/09/2021

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

(X4) ID PREFIX TAG	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 686	Continued From page 7	F 686		

be completed.

When interviewed via phone 3/10/21, at 12:29 p.m. LPN-C stated she worked the evening of 2/27/21, and was not notified by RN-B that the wound care still needed to be completed for R2's right hip. LPN-C did not note the treatment had not been signed out by the previous shift.

R2's Wound Evaluation and Management Summary dated 3/1/21, completed by MD-A, noted measurements of 7.2 cm x 6 cm x 3.2 cm. The undermining measurement was 5.2 cm at 5 o'clock. The drainage was described as moderate amount of serous (thin and watery and usually clear to yellowish or brownish appearance). The wound bed was described as 50% slough (yellowish/white material. Consists of dead cells that harbor organisms like bacteria, fungus, etc and slow/stop healing process. It can increase the risk of infection) and 50% granulation tissue. The summary also identified the wound progress had, "Deteriorated," a culture was taken and an antibiotic started. The would required surgical debridement and a diagnosis was added, "Stage 4 pressure wound of the right buttocks- deteriorated due to infection."

R2's late entry progress note dated 3/2/2, 4:05 a.m. included, "At around 2 to 3 am resident's wound vac was beeping, and upon checking it was clogged, writer and the aide tried to look for an extra to replace the canister [the canister collects the wound drainage from the wound vac] but can't find anything. Contacted the supplier to ask if can deliver the canister ASAP and the lady the writer spoke with, will try if the [sic] can and promised to call back. And the other nurse received a call back and she was told that the

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 03/09/2021

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

(X4) ID PREFIX TAG	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 686	Continued From page 8	F 686		

canister will be delivered in the morning, during business hours, 3.2.21. Res [resident] turn off the machine since it was beeping and distracting. Will endorse to the AM nurse."

When interviewed 3/10/21, at 10:50 a.m. the ADON stated there were numerous canisters in the box when the wound vac had been delivered and did not know why there had been none available to replace the canister on 3/2/21. If there were no canisters available the nurse should have contacted the provider and request a different treatment order.

R2's progress note dated 3/2/21, at 5:23 p.m. included, "Resident sent Abbott Northwestern hospital via Allina EMS at 1720 [5:20 p.m.].

When interviewed via telephone on 3/9/21, at 9:32 a.m. R2 stated, she was sent to Abbott Northwestern Hospital 3/2/21. She was admitted to the nursing home 2/19/21 and stated the staff at the facility started the wound vac on 2/22/21. No other treatment to her right hip had been completed while waiting for the wound vac to arrive. The wound care was ordered for 3 times per week, and the last date of the wound care was 2/25/21. The wound care scheduled for 2/27/21 was not performed, she did not know why. The dressing did not get changed and wound care did not get completed again until 3/2/21 when the wound care doctor came. Overnight on 3/1/21, the, "machine started beeping and the staff were unable to get it to stop." She reported that the canister on the wound vac was full and the staff were "unable to find a replacement, so they turned the wound vac off." The wound vac remained off until the wound care doctor came and evaluated the wound. The

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 03/09/2021

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

(X4) ID PREFIX TAG	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 686	Continued From page 9	F 686		

wound doctor reported to her that the wound, "wasn't clean enough to restart the wound vac." R2 stated the hip infection turned out to be a staph infection (an infection caused by a bacteria found on human skin, in the nose, armpit, groin, and other areas).

When interviewed 3/9/21, at 2:05 p.m. wound doctor MD-A stated the wound on the right hip, "looked good" on her first visit [2/23/21], "it was nice and granular." On the second visit [3/1/21], she was concerned about the hip wound. [R2] told her they wouldn't change the dressings. The hip wound had deteriorated. It was gray and odorous, which was a, "huge change," from the previous week when had seen it. MD-A stated, the nurse told her they had issues with the wound vac cartridge and hadn't been running the wound vac since the previous night. MD-A was going to restart the wound vac after wound rounds, but the wound, "wasn't clean enough to put the wound vac back on." MD-A called the primary physician's nurse practitioner (NP)-A and told her the wound looked infected. NP-A decided to send R2 to Abbott Northwestern Hospital.

When interviewed 3/10/21, at 4:03 p.m. NP-A stated the main reason she sent [R2] to the hospital on 3/2/21, was for issues with uncontrolled pain and for a wound evaluation. [R2] was experiencing increasing pain after her recent spine surgery. NP-A received a call on 3/2/21 from MD-A stating R2's wound looked infected and MD-A had written new wound care orders and started antibiotics. NP-A contacted the physician assistant for [R2]'s neurosurgeon to inform them of her uncontrolled pain. The neurosurgery physician assistant requested [R2] be sent to the emergency department for imaging

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 03/09/2021

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

(X4) ID PREFIX TAG	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 686	Continued From page 10	F 686		

and an infectious disease evaluation. NP-A was unaware that the wound vac that was ordered to be started on the day of admission, 2/19/21, was not started until 2/22/21. NP-A was also unaware that on 3/2/21, between 2:00 am - 3:00 am, there was a problem with the wound vac, and since there was no replacement canister in the facility, the machine was turned off. NP-A stated, the delay in starting the wound vac, not obtaining alternate orders, missed dressing change on 2/27/21, and shutting the wound vac off on 3/2/21, would have resulted in deterioration of the pressure ulcer. NP-A stated she should have been notified of all of these issues, and if had been notified, would have made order changes. When interviewed by phone on 3/11/21, at 9:25 a.m. NP-A stated, the provider should have been notified, "if they don't have the proper equipment, or the ability to do wound the wound care."

When interviewed by phone on 3/11/21, at 11:03 a.m. MD-A stated, the delay in starting the wound vac, with no other treatment ordered, the missed wound care on 2/27/21, and shutting the wound vac off with no other treatment orders could have the caused deterioration to R2's iliac crest pressure ulcer.

When interviewed by phone on 3/11/21, at 9:00 a.m. R2's social worker at Abbott Northwestern Hospital stated, "R2 was readmitted because of worsening low back pain and for wound evaluation. They found she has some infection. Per the Infectious Disease note, she has staph aureus in the blood (sepsis) which may be originating from sacral wound, or may be originating from the spine as MRI (magnetic resonance imaging, a form of x-ray) showed. Per infectious disease note, they are not clear of the

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 03/09/2021

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

(X4) ID PREFIX TAG	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 686	Continued From page 11	F 686		

origin of the sepsis."

A Wound Care procedure document dated October, 2010, indicated the purpose was to provide guidelines for the care of wounds to promote healing. This document indicated the following information should be recorded in the resident's medical record: the type of wound care given, the date and time the wound care was given, the position in which the resident was placed, the name and title of the individual performing the wound care, any change in the resident's condition, all assessment data (wound bed color, size, drainage, etc.) obtained when inspecting the wound, how the resident tolerated the procedure, any problems or complaints made by the resident related to the procedure, if the resident refused the treatment and why, and the signature and title of the person recording the data. This document also included, what to report: Notify the supervisor if the resident refuses the wound care. Report other information in accordance with facility policy and professional standards of practice.

A facility Skin Assessment and Wound Management policy, last revised, July 2018, provided guidelines for assessing and managing wounds. The policy directed that with ongoing skin problems related to pressure ulcers, document skin condition on the Pressure Wound Evaluation weekly, until healed; update provider and resident/representative as needed; review skin concerns with interdisciplinary team at least monthly; update care plan as needed. It also indicated wound care will be provided per nursing or provider order; document treatment or refusal of treatment in the resident's medical record.

Electronically delivered
March 29, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: LNAL11

Dear Administrator:

The above facility was surveyed on March 9, 2021 through March 9, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

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

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

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

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

Karen Aldinger, Unit Supervisor
Metro C District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program

Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

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 03/09/2021

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

(X4) ID PREFIX TAG	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) COMPLETE DATE
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 3/9/21 through 3/11/21, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be not in compliance with the MN State Licensure. The following complaint was found to be substantiated: H5298107C (MN00070564).	2 000		

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 03/09/2021

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

(X4) ID PREFIX TAG	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) COMPLETE DATE
2 000	Continued From page 1 Licensing order was issued at 0900. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS	2 000		

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 03/09/2021

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

(X4) ID PREFIX TAG	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) COMPLETE DATE
2 000	Continued From page 2 APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide pressure ulcer care per physician orders, and notify the physician when they were unable to provide the ordered wound care for 1 of 2 residents (R2) reviewed who had pressure ulcers. This resulted in actual harm for R2 when the pressure ulcer deteriorated, became infected, and R2 was hospitalized for sepsis. Findings include: R2's 5 day PPS Minimum Data Set (MDS) dated 2/26/21, included cognitively intact, required	2 900	Corrected.	3/15/21

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 03/09/2021

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

(X4) ID PREFIX TAG	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) COMPLETE DATE
2 900	Continued From page 3 extensive assistance with bed mobility, transfers and hygiene. R2 had 5 stage 4 pressure ulcers (Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling) and 1 unstageable pressure ulcer (Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar), which were all present upon admission. An admission MDS had not been completed. R2's Braden Scale (scale used to determine pressure ulcer risk) dated 2/20/21, identified risk factors of confined to bed, very limited mobility, friction and shear concern. R2 had diagnoses of paraplegic (paralysis of the legs and lower body), needed to be repositioned every 2 hours and had a stage 4 pressure ulcer on right buttocks. R2's care plan dated 2/22/21, identified R2 as having an alteration in skin integrity, pressure ulcer to right iliac crest (the curved upper border of the ileum which is the largest of the three bones that form the hip bone), stage 4. Staff were directed to: Monitor skin integrity during cares. Weekly skin inspection by nurse. Treatment to open areas per order. Monitor for skin breakdown and for signs and symptoms of infection. Report signs and symptoms to MD (doctor) or physician assistant. Document on skin condition and keep MD/physician assistant informed. R2's Physician's orders for wound care dated 2/19/21, directed staff to, change right iliac crest dressing and perform wound care three times per week. Irrigate wound thoroughly with Microcyn (antimicrobial wound cleanser) wound cleanser.	2 900		

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 03/09/2021

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

(X4) ID PREFIX TAG	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) COMPLETE DATE
2 900	Continued From page 4 Pat dry. Paint intact skin surrounding wound with Cavilon- no sting barrier film. Cut wound vac (foam dressing in the wound bed connected to suction, to help aid in wound healing) foam dressing to fit wound and apply to wound bed. If bridging, (intact skin between open areas) be sure to apply drape to intact skin under the foam to protect skin from injury. Cover foam and bridge with vac drape to achieve seal. Set negative pressure at 125 mm Hg (millimeters of mercury/ a unit of pressure) continuous. Change on evening shift. R2's treatment administration record (TAR) for February 2021, showed no documentation from to ensure the wound vac was on and functioning properly every shift, from admission on 2/19/21, until the evening shift on 2/22/21, three days after admission. No other treatment to the stage 4 pressure ulcer on R2's right iliac crest had been identified. R2's medical record did not identify if R2's provider had been notified the wound vac to right iliac crest had not been implemented. When interviewed via phone on 3/10/21, at 12:06 p.m. the Operations Supervisor (OS) at Northwestern Respiratory (company that supplies wound vac and supplies to the facility) stated the intake department received an order for a wound vac for R2 on 2/18/21, at 5:00 pm. The driver delivered the wound vac at 7:15 p.m. that same day. The driver was required to hand supplies to a nurse to sign for the delivery of the wound vac. When interviewed via phone on 3/10/21, at 2:51 p.m. licensed practical nurse (LPN)-B stated she worked the evening of 2/18/21, and remembered signing for a wound vac set up that was delivered to facility. LPN-B delivered it to the transitional care side of facility and placed the package on	2 900		

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 03/09/2021

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

(X4) ID PREFIX TAG	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) COMPLETE DATE
2 900	Continued From page 5	2 900		

top of the counter at the nurses station. LPN-B had reported there was a delivery to, "someone," but could not remember who. LPN-B was not responsible for R2 that evening.

R2's progress note dated 2/19/21, at 3:24 p.m. included, "Patient has many wounds on BLE [bilateral lower extremities] and one wound on right side of hip that a wound vac has been ordered for. Due to severe pain, wound on right hip was not measured and PM nurse was notified to measure when wound vac comes prior to placing on wound."

When interviewed on 3/9/21, at 11:10 a.m. LPN-A stated she had admitted R2 on 2/19/21, and had measured all wounds except the one on her iliac crest, as R2 was having too much pain. She passed the information on to the afternoon shift to complete when the wound vac arrived. LPN-A did not know the wound vac had been delivered on 2/18/21.

R2's progress note dated 2/19/21, at 10:05 p.m. included, "New resident admitted to facility today. She c/o [complained of] excruciating pain all over body. Dressing did not get completed due to pain. Resident given PRN [per resident need or as needed] and scheduled pain medications that helped some, but not enough. Wound vac not delivered this shift."

When interviewed via phone on 3/11/21, at 9:25 am, registered nurse (RN)-C stated she was working the evening R2 was admitted on 2/19/21. R2 was in so much pain when she got to the facility. RN-C stated she offered to do wound care, but R2 refused due to pain. RN-C stated the wound vac did not arrive on her shift. RN-C reported she did not notify the physician of the

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 03/09/2021

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

(X4) ID PREFIX TAG	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) COMPLETE DATE
2 900	Continued From page 6	2 900		

refusal of wound care or that the wound vac hadn't arrived. RN-C was not aware of any facility policy of when to notify the provider. RN-C was not aware the wound vac had been delivered on 2/18/21.

R2's progress note dated 2/21/21, at 2:10 p.m. included, "Call placed to Northwest oxygen to find out status of wound vac ordered Friday. Order resent and wound vac to be delivered this pm." This was 2 days since R2 was admitted. There was no evidence in the medical record R2's provider had been contacted and orders obtained on how to manage the wound to her right iliac crest if the wound vac was not available.

When interviewed via phone on 3/10/21, at 12:06 p.m. OS at Northwestern Respiratory stated, "The on-call service received a call 2/21/21, stating the facility had not received wound vac. Driver was unable to see in the database that a wound vac had already been delivered 2/18/21; therefore another wound vac was delivered 2/21/21. We then picked up the extra wound vac on Wednesday [2/24/21]."

R2's progress note dated 2/22/21, at 1:36 p.m. included, wound vac "changed" this shift. When interviewed 3/10/21, 10:50 am, the writer of the note, RN-A, clarified, "The wound vac was started, not changed." This was 3 days after admission.

When interviewed on 3/10/21, at 10:50 a.m. the assistant director of nursing (ADON), stated the wound vac was delivered 2/21/21 with the incorrect tubing. The ADON stated that the improper tubing delivery 2/21/21, "was likely the reason the wound vac wasn't started [2/21/21] once delivered." The ADON stated she was

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 03/09/2021

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

(X4) ID PREFIX TAG	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) COMPLETE DATE
2 900	Continued From page 7	2 900		

unsure what, if any, wound care had been done between 2/19/21 -2/22/21, when the wound vac wasn't being used. The ADON stated when there was an issue with the wound vac, the doctor should have been notified for an alternate treatment plan. However, R2's provider had not been notified and no wound care orders had been received.

R2's Initial Wound Evaluation and Management Summary dated 2/23/21, from a wound physician MD-A, identified a stage 4 pressure ulcer to the right buttocks. The wound measured 8 cm (centimeters) by 5.8 cm by 3.1 cm. The wound contained undermining (occurs when the tissue under the wound edges becomes eroded, resulting in a pocket beneath the skin at the wound's edge) present with measurements 2.5 cm at 1 o'clock (location of undermining in comparison to the time on a clock). Drainage was described as moderate sero-sanguineous (yellowish with small amounts of blood). Wound bed showed 100% granulation tissue (light red or pink in color, and moist. An indicator of healing).

R2's treatment administration record (TAR) for February 2021, identified R2 was to receive the physician ordered treatment to the right iliac 3 times per week on Tuesdays, Thursdays and Saturdays. The treatment ordered was: change right iliac crest dressing and perform wound care three times per week. Irrigate wound thoroughly with Microcyn (antimicrobial wound cleanser) wound cleanser. Pat dry. Paint intact skin surrounding wound with Cavilon- no sting barrier film. Cut wound vac (foam dressing in the wound bed connected to suction, to help aid in wound healing) foam dressing to fit wound and apply to wound bed. If bridging, (intact skin between open areas) be sure to apply drape to intact skin under

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 03/09/2021

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

(X4) ID PREFIX TAG	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) COMPLETE DATE
2 900	Continued From page 8	2 900		

the foam to protect skin from injury. Cover foam and bridge with vac drape to achieve seal. Set negative pressure at 125 mm Hg (millimeters of mercury/ a unit of pressure) continuous. The treatment was not signed out as being completed on Saturday 2/27/21, with the last treatment being identified on 2/25/21.

When interviewed via phone 3/11/21, at 10:52 a.m. registered nurse (RN)-B stated she worked the evening of 2/27/21, and was unable to complete scheduled wound care during her shift due to not enough time. RN-B reported to LPN-C that wound care to right iliac crest still needed to be completed.

When interviewed via phone 3/10/21, at 12:29 p.m. LPN-C stated she worked the evening of 2/27/21, and was not notified by RN-B that the wound care still needed to be completed for R2's right hip. LPN-C did not note the treatment had not been signed out by the previous shift.

R2's Wound Evaluation and Management Summary dated 3/1/21, completed by MD-A, noted measurements of 7.2 cm x 6 cm x 3.2 cm. The undermining measurement was 5.2 cm at 5 o'clock. The drainage was described as moderate amount of serous (thin and watery and usually clear to yellowish or brownish appearance). The wound bed was described as 50% slough (yellowish/white material. Consists of dead cells that harbor organisms like bacteria, fungus, etc and slow/stop healing process. It can increase the risk of infection) and 50% granulation tissue. The summary also identified the wound progress had, "Deteriorated," a culture was taken and an antibiotic started. The would required surgical debridement and a diagnosis was added, "Stage 4 pressure wound of the right

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 03/09/2021

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

(X4) ID PREFIX TAG	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) COMPLETE DATE
2 900	Continued From page 9 buttocks- deteriorated due to infection." R2's late entry progress note dated 3/2/2, 4:05 a.m. included, "At around 2 to 3 am resident's wound vac was beeping, and upon checking it was clogged, writer and the aide tried to look for an extra to replace the canister [the canister collects the wound drainage from the wound vac] but can't find anything. Contacted the supplier to ask if can deliver the canister ASAP and the lady the writer spoke with, will try if the [sic] can and promised to call back. And the other nurse received a call back and she was told that the canister will be delivered in the morning, during business hours, 3.2.21. Res [resident] turn off the machine since it was beeping and distracting. Will endorse to the AM nurse." When interviewed 3/10/21, at 10:50 a.m. the ADON stated there were numerous canisters in the box when the wound vac had been delivered and did not know why there had been none available to replace the canister on 3/2/21. If there were no canisters available the nurse should have contacted the provider and request a different treatment order. R2's progress note dated 3/2/21, at 5:23 p.m. included, "Resident sent Abbott Northwestern hospital via Allina EMS at 1720 [5:20 p.m.]. When interviewed via telephone on 3/9/21, at 9:32 a.m. R2 stated, she was sent to Abbott Northwestern Hospital 3/2/21. She was admitted to the nursing home 2/19/21 and stated the staff at the facility started the wound vac on 2/22/21. No other treatment to her right hip had been completed while waiting for the wound vac to arrive. The wound care was ordered for 3 times per week, and the last date of the wound care	2 900		

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 03/09/2021

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

(X4) ID PREFIX TAG	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) COMPLETE DATE
2 900	Continued From page 10	2 900		

was 2/25/21. The wound care scheduled for 2/27/21 was not performed, she did not know why. The dressing did not get changed and wound care did not get completed again until 3/2/21 when the wound care doctor came. Overnight on 3/1/21, the, "machine started beeping and the staff were unable to get it to stop." She reported that the canister on the wound vac was full and the staff were "unable to find a replacement, so they turned the wound vac off." The wound vac remained off until the wound care doctor came and evaluated the wound. The wound doctor reported to her that the wound, "wasn't clean enough to restart the wound vac." R2 stated the hip infection turned out to be a staph infection (an infection caused by a bacteria found on human skin, in the nose, armpit, groin, and other areas).

When interviewed 3/9/21, at 2:05 p.m. wound doctor MD-A stated the wound on the right hip, "looked good" on her first visit [2/23/21], "it was nice and granular." On the second visit [3/1/21], she was concerned about the hip wound. [R2] told her they wouldn't change the dressings. The hip wound had deteriorated. It was gray and odorous, which was a, "huge change," from the previous week when had seen it. MD-A stated, the nurse told her they had issues with the wound vac cartridge and hadn't been running the wound vac since the previous night. MD-A was going to restart the wound vac after wound rounds, but the wound, "wasn't clean enough to put the wound vac back on." MD-A called the primary physician's nurse practitioner (NP)-A and told her the wound looked infected. NP-A decided to send R2 to Abbott Northwestern Hospital.

When interviewed 3/10/21, at 4:03 p.m. NP-A stated the main reason she sent [R2] to the

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 03/09/2021

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

(X4) ID PREFIX TAG	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) COMPLETE DATE
2 900	Continued From page 11	2 900		

hospital on 3/2/21, was for issues with uncontrolled pain and for a wound evaluation. [R2] was experiencing increasing pain after her recent spine surgery. NP-A received a call on 3/2/21 from MD-A stating R2's wound looked infected and MD-A had written new wound care orders and started antibiotics. NP-A contacted the physician assistant for [R2]'s neurosurgeon to inform them of her uncontrolled pain. The neurosurgery physician assistant requested [R2] be sent to the emergency department for imaging and an infectious disease evaluation. NP-A was unaware that the wound vac that was ordered to be started on the day of admission, 2/19/21, was not started until 2/22/21. NP-A was also unaware that on 3/2/21, between 2:00 am - 3:00 am, there was a problem with the wound vac, and since there was no replacement canister in the facility, the machine was turned off. NP-A stated, the delay in starting the wound vac, not obtaining alternate orders, missed dressing change on 2/27/21, and shutting the wound vac off on 3/2/21, would have resulted in deterioration of the pressure ulcer. NP-A stated she should have been notified of all of these issues, and if had been notified, would have made order changes. When interviewed by phone on 3/11/21, at 9:25 a.m. NP-A stated, the provider should have been notified, "if they don't have the proper equipment, or the ability to do wound the wound care."

When interviewed by phone on 3/11/21, at 11:03 a.m. MD-A stated, the delay in starting the wound vac, with no other treatment ordered, the missed wound care on 2/27/21, and shutting the wound vac off with no other treatment orders could have the caused deterioration to R2's iliac crest pressure ulcer.

When interviewed by phone on 3/11/21, at 9:00

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 03/09/2021

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

(X4) ID PREFIX TAG	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) COMPLETE DATE
2 900	Continued From page 12 a.m. R2's social worker at Abbott Northwestern Hospital stated, "R2 was readmitted because of worsening low back pain and for wound evaluation. They found she has some infection. Per the Infectious Disease note, she has staph aureus in the blood (sepsis) which may be originating from sacral wound, or may be originating from the spine as MRI (magnetic resonance imaging, a form of x-ray) showed. Per infectious disease note, they are not clear of the origin of the sepsis." A Wound Care procedure document dated October, 2010, indicated the purpose was to provide guidelines for the care of wounds to promote healing. This document indicated the following information should be recorded in the resident's medical record: the type of wound care given, the date and time the wound care was given, the position in which the resident was placed, the name and title of the individual performing the wound care, any change in the resident's condition, all assessment data (wound bed color, size, drainage, etc.) obtained when inspecting the wound, how the resident tolerated the procedure, any problems or complaints made by the resident related to the procedure, if the resident refused the treatment and why, and the signature and title of the person recording the data. This document also included, what to report: Notify the supervisor if the resident refuses the wound care. Report other information in accordance with facility policy and professional standards of practice. A facility Skin Assessment and Wound Management policy, last revised, July 2018, provided guidelines for assessing and managing wounds. The policy directed that with ongoing skin problems related to pressure ulcers,	2 900		

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 03/09/2021

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

(X4) ID PREFIX TAG	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) COMPLETE DATE
2 900	Continued From page 13 document skin condition on the Pressure Wound Evaluation weekly, until healed; update provider and resident/representative as needed; review skin concerns with interdisciplinary team at least monthly; update care plan as needed. It also indicated wound care will be provided per nursing or provider order; document treatment or refusal of treatment in the resident's medical record. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development and/or heal current pressure ulcers. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		