



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 24, 2026

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

RE: CCN:245298

Cycle Start Date: July 2, 2026

Dear Administrator:

On July 2, 2026, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Deb Willis, Regional Operations Supervisor
Health Regulation Division
Minnesota Department of Health
St. Cloud District Office
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: Deborah.Willis@state.mn.us
Office: (320) 223-7374 Mobile: (320) 423-0619

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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by October 2, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by January 2, 2027 (six months after the identification of noncompliance) your provider agreement will be terminated.

This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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:

<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for

the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at:

https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:

<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/02/2026	
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 305 FREMONT STREET , ANOKA, Minnesota, 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
E0000	Initial Comments On 6/29/26 through 7/2/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.			E0000			
F0000	INITIAL COMMENTS On 6/29/26 through 7/2/26, a standard recertification survey (S5298043-0) was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H52983075C (3025593) H52983076C (2984126) H52983077C (2726361) H52983079C (2693115) H52983081C (2647041) The following complaint was reviewed: H52983080C (2686673) with deficiencies cited at F677. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification			F0000			

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 reverse for further 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.

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

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F0000	Continued from page 1 of compliance.			F0000			
F0550 SS = D	Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained. Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.			F0550			

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F0550 SS = D	Continued from page 2 This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a resident's dignity was maintained when a nephrostomy drainage bag (collection pouch that gathers urine directly from a tube surgically placed in the kidney) was left uncovered and visible from the hallway for 1 of 1 resident (R5) reviewed for dignity. Findings include: R5's quarterly Minimum Data Set (MDS), dated 5/19/26, identified R5 had moderate cognitive impairment, required assistance with activities of daily living (ADLs), and diagnoses included multiple sclerosis (a disease affecting the brain and spinal cord causing weakness and decreased physical function), and neurogenic bladder (loss of bladder control due to a nerve problem). The MDS further identified R5 had an indwelling catheter. R5's care plan, dated 6/1/26, identified R5 was incontinent of bowel and bladder related to multiple sclerosis and decreased mobility. The care plan identified R5 had a left nephrostomy tube due to kidney stones and a Foley catheter. The care plan directed staff to provide incontinence care, monitor for signs and symptoms of a UTI, empty the left nephrostomy as ordered, and ensure R5 was appropriately covered and dignity was provided. During an observation on 7/1/26 at 12:42 p.m., R5 was seated in a Broda wheelchair in his room with the door open to the hallway. R5's nephrostomy drainage bag was hanging uncovered from the left armrest of the chair. The uncovered nephrostomy drainage bag was visible from the hallway to anyone who walked by R5's room. During an observation and interview on 7/1/26 at 12:47 p.m., trained medication aide (TMA)-A entered R5's room with R5's meal tray. TMA-A stated the nephrostomy drainage bag was usually hung on the armrest of R5's wheelchair. During an interview on 7/1/26 at 1:08 p.m., the registered nurse case manager (RNCM) and director of nursing (DON) confirmed R5's nephrostomy drainage bag was not covered and was visible from the hallway. The RNCM and DON stated the nephrostomy drainage bag should have been covered because the uncovered bag was a dignity concern.			F0550			

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F0550 SS = D	Continued from page 3 The facility's Combined Federal and State Bill of Rights policy, dated 11/28/16, identified residents had the right to a dignified existence. The policy indicated the facility must treat each resident with respect and dignity and provide care in a manner and environment that promoted maintenance or enhancement of the resident's quality of life, recognized each resident's individuality, and protected and promoted resident rights.			F0550			
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels.			F0584			

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F0584 SS = D	Continued from page 4 Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to maintain resident equipment in a clean and sanitary manner for 1 of 1 resident (R14) reviewed for a safe, clean, comfortable, and homelike environment. Findings include: R14's quarterly Minimum Data Set (MDS), dated 5/22/26, identified R14 had severe cognitive impairment, required assistance with activities of daily living (ADLs), and diagnoses included stroke, hemiplegia, and dementia. During an observation on 6/29/26 at 1:23 p.m., R14's wheelchair was visibly soiled and the wheelchair frame had an accumulation of dirt and debris. The back of the wheelchair, behind the seat, had a buildup of dirt and debris. The wheelchair seat had a brown substance adhered to the edge of the seat, and food remnants were observed on the seat. During an observation on 6/30/26 at 9:33 a.m., R14 was lying in bed, and R14's wheelchair remained visibly soiled with previously identified dirt and debris. During an observation on 6/30/26 at 4:51 p.m., R14 was lying in bed, and R14's wheelchair remained visibly soiled with accumulated dirt and debris. During an observation on 7/1/26 at 9:33 a.m., R14 was seated in the wheelchair in R14's room. R14's wheelchair remained visibly soiled with accumulated dirt and debris. During an observation on 7/2/26 at 8:24 a.m., R14 was seated in the wheelchair in R14's room. R14's wheelchair remained visibly soiled with accumulated dirt and debris. During an interview on 7/2/26 at 12:08 p.m., nursing assistant (NA)-A stated night shift staff were responsible for cleaning resident wheelchairs when the wheelchairs were identified as dirty. During an interview on 7/2/26 at 1:24 p.m., the			F0584			

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F0584 SS = D	Continued from page 5 registered nurse case manager (RNCM) and director of nursing (DON) confirmed R14's wheelchair was visibly soiled with debris present on the wheelchair frame and seat. RNCM and DON stated the condition of the wheelchair was a concern and created an infection control concern. RNCM and DON stated nursing assistants were responsible for cleaning resident wheelchairs. RNCM and DON further stated wheelchairs should have been cleaned by night shift when residents were out of the chairs, and cleaned weekly during residents' scheduled showers. The facility's Wheelchair Cleaning Policy, undated, identified the purpose of the policy was to maintain a clean, safe, and homelike environment by ensuring wheelchairs were cleaned regularly. The policy directed staff to clean wheelchairs with mild detergent and water prior to disinfecting when wheelchairs were visibly soiled. The policy further directed staff to clean and disinfect all areas, including push handles, seat and backrest, armrests, footrests, leg rests, seat belts/straps, hand rims, brakes, wheelchair frames, cushions, and all high-touch surfaces. The policy indicated deep cleaning of wheelchairs was to be completed by night shift on residents' bath days and identified all staff were responsible for cleaning and disinfecting wheelchairs immediately when visibly soiled.			F0584			
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is			F0605			

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F0605 SS = D	Continued from page 6 not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.			F0605			

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F0605 SS = D	Continued from page 7 §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure a psychotropic medication prescribed on an as-needed (PRN) basis was limited to 14 days, or had documentation from the prescribing practitioner with a rationale for continued use beyond 14 days, for 1 of 5 residents (R19) reviewed for unnecessary medications. Findings include: R19's significant change in status Minimum Data Set (MDS), dated 5/27/26, identified R19 had moderately impaired cognition and diagnoses included			F0605			

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F0605 SS = D	Continued from page 8 depression and chronic pain. The MDS further identified R19 received antianxiety and opioid (pain medication) medications. R19's care plan, dated 6/26/26, identified R19 was at risk for psychotropic medication adverse drug reactions (ADRs) related to the use of psychotropic medications and/or other medications used to treat a psychotropic indication. The care plan goal indicated R19 would not experience ADRs related to the current psychotropic medication regimen. Interventions directed staff to administer medications as ordered, monitor target behaviors and ADRs, report suspected ADRs to the medical provider, ensure medications were reviewed by the medical provider and pharmacist, and update the medical provider regarding medication effectiveness and/or ADRs as needed. R19's physician orders, dated 6/29/26, included an order initiated on 5/21/26 for lorazepam solutab (an antianxiety psychotropic medication) 0.5 milligrams (mg) by mouth every four hours as needed (PRN) for anxiety/restlessness. The order lacked a stop date and allowed the PRN psychotropic medication to remain available for use beyond 14 days. However, R19's electronic health record (EHR) lacked documentation the prescribing practitioner documented a clinical rationale for continued use of PRN lorazepam beyond 14 days. During an interview on 7/2/26 at 1:24 p.m., the registered nurse case manager (RNCM) and Director of Nursing (DON) reviewed R19's medical record and confirmed R19's PRN lorazepam order lacked a 14-day stop date. The RNCM and DON stated PRN psychotropic medications required a 14-day stop date unless the resident was receiving hospice services and the provider specified the duration. The RNCM stated the order should have been clarified with the provider. The RNCM and DON stated monitoring PRN psychotropic medications was important due to the potential for adverse side effects, and PRN use should not be prolonged without review. The RNCM and DON stated staff needed to monitor medication use, communicate with the provider, and evaluate if medication changes were needed based on the resident's continued use. A facility policy related to psychotropic medication use and PRN psychotropic medication duration requirements was requested; however, the facility did not provide a policy prior to the end of the survey.			F0605			

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NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 305 FREMONT STREET , ANOKA, Minnesota, 55303			
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F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to provide grooming assistance according to a resident's assessed needs and preferences for 1 of 1 resident (R8) reviewed for activities of daily living (ADL) care. Findings include: R8's quarterly Minimum Data Set (MDS), dated 5/19/26, identified R8 had severe cognitive impairment, required staff assistance with activities of daily living (ADLs), and diagnoses included stroke, dementia, and hemiplegia (weakness or paralysis affecting one side of the body). R8's care plan, printed 6/30/26, identified R8 had a self-care deficit related to weakness and dementia. The care plan identified R8 had a history of being combative with cares, yelled out instead of using the call light, and would be dressed, groomed, and bathed according to his preferences. Interventions directed staff to re-approach R8 if cares or treatments were refused, respect R8's choices, and document refusals. The care plan further identified R8 required assistance of one staff member with grooming and identified R8's shaving preference was to be shaved daily. A Vulnerable Adult Maltreatment Report, dated 12/8/25, identified family member (FM)-A reported R8's beard trimming had not occurred. During observation on 6/30/26 at 4:05 p.m., R8 was lying in bed with a full beard of approximately one to two inches in length. During observation on 7/1/26 at 12:21 p.m., R8 was seated at a table while a nursing assistant (NA) assisted R8 with eating. R8 continued to have a full beard of approximately one to two inches in length. During an interview on 7/2/26 at 12:08 p.m., NA-A stated staff should offer shaving assistance and notify the nurse if a resident refused. NA-A stated R8's beard was normal for him, staff did not shave him, and stated, "I think he likes to have a beard."			F0677			

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F0677 SS = D	Continued from page 10 NA-A was unable to provide evidence R8 refused shaving assistance. During an interview on 7/2/26 at 1:24 p.m., the registered nurse case manager (RNCM) and Director of Nursing (DON) stated R8's beard had been present for a while. The RNCM and DON stated they expected staff to offer shaving assistance, and if R8 refused, the refusal should have been documented. The RNCM and DON reviewed R8's medical record and confirmed there was no specific task established for shaving, and acknowledged R8's care plan identified his preference was to be shaved daily. The facility's Activities of Daily Living (ADLs)/Maintain Abilities Policy, updated 3/31/23, identified the facility would create and sustain an environment that individualized each resident's quality of life by ensuring care and services were person-centered and honored each resident's preferences, choices, values, and beliefs. The policy indicated, based on the comprehensive assessment and consistent with the resident's needs and choices, the facility would provide necessary care and services. The policy further indicated residents who were unable to carry out activities of daily living would receive necessary services to maintain grooming and personal hygiene.			F0677			
F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition			F0690			

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F0690 SS = D	Continued from page 11 demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a nephrostomy drainage system was positioned to allow unobstructed dependent drainage of urine for 1 of 1 resident (R5) reviewed for indwelling catheter care. Findings include: R5's quarterly Minimum Data Set (MDS), dated 5/19/26, identified R5 had moderately impaired cognition, required assistance with activities of daily living (ADLs), and diagnoses included multiple sclerosis and neurogenic bladder (lack of bladder control due to nerve problems), and septicemia (severe infection in the bloodstream). The MDS further identified R5 had an indwelling urinary catheter. R5's care plan, printed 7/1/26, identified R5 had an alteration in elimination and was incontinent of bowel and bladder related to multiple sclerosis (MS), decreased mobility, left nephrostomy tube related to kidney stones, and Foley catheter placement. The care plan directed staff to monitor for signs and symptoms of UTIs, provide perineal care, and empty the left nephrostomy as ordered. During observation on 7/1/26 at 12:42 p.m., R5 was seated in a Broda wheelchair in his room with the door open to the hallway. R5's nephrostomy drainage bag was observed hanging from the left armrest of the wheelchair. The nephrostomy tubing was positioned off the side of the wheelchair and above the insertion site, which prevented dependent drainage of urine. The position of the tubing did not allow urine to flow freely away from the insertion site and created the potential for urine backflow. During observation on 7/1/26 at 12:47 p.m., trained			F0690			

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F0690 SS = D	Continued from page 12 medication aide (TMA)-A stated R5's nephrostomy drainage bag was hung from the wheelchair armrest and that it was typically hung this way. During an interview on 7/1/26 at 1:08 p.m., the registered nurse case manager (RNCM) and director of nursing (DON) observed R5's nephrostomy drainage system. The RNCM and DON confirmed the nephrostomy bag and tubing were positioned incorrectly and stated the placement did not allow urine to drain appropriately. The DON stated the nephrostomy drainage bag needed to remain below the insertion site to allow urine to flow freely and reduce the risk of urinary tract infections (UTIs). The facility's Indwelling Catheter Care Procedure, last reviewed 5/2025, directed staff to provide appropriate care of urinary drainage systems. The policy directed staff to place drainage tubing over the resident's leg and check the tubing for evidence of urine flow.			F0690			
F0880 SS = D	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 §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify			F0880			

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F0880 SS = D	Continued from page 13 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 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 appropriate infection control practices were performed for 1 of 2 residents (R4) reviewed for installation of eye drops. Findings include: R4's annual Minimum Data Set			F0880			

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F0880 SS = D	Continued from page 14 (MDS), dated 4/23/26, indicated R4 was cognitively intact, and diagnoses included diabetes, schizophrenia, depression, and anxiety. R4's physician's orders, printed 7/2/26, indicated an order for prednisolone acetate ophthalmic suspension 1 % (corticosteroid eye drops) to his right eye after having cataract surgery. During a medication pass observation on 6/30/26 at 4:32 p.m., registered nurse (RN)-B, after setting up R4's medications, which included prednisolone eye drops, entered R4's room. RN-B gave R4 his oral meds and inhaler. RN-B instructed R4 to tilt his head back, used her ungloved fingers to spread R4's eye lids (upper and lower), held them open and instilled the eye drop in R4's right eye. RN-A offered a tissue, exited room, walked back to the medication cart and placed R4's eye drop bottle back in the cart. During an interview on 6/30/26 at 4:41 p.m., RN-A stated she forgot to wash her hands and put on gloves before R4's eye drops were administered, and RN-A stated she should have washed her hands after the eye drops were given before she left the room. RN-A stated, "I forgot, I am so sorry." During an interview on 7/2/26 at 10:37 a.m., the director of nursing (DON) and corporate registered nurse (CRN) both stated RN-B should have washed her hands, donned gloves, given the eye drops, doffed her gloves and washed hands after the eye drops were administered. The facility's Eye Drop, Ointment, and Gel Medications Administration procedure, undated, indicated before the administration of eye drops, staff will perform hand hygiene, put on examination gloves, and with a gloved finger, gently pull-down lower eyelid to form a "pouch". After the administration of eye drops, staff will remove gloves and wash hands thoroughly with antimicrobial soap and water or facility approved hand sanitizer.			F0880			
F0883 SS = D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated			F0883			

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F0883 SS = D	Continued from page 15 or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 5 residents (R12) were offered, educated on, and provided the pneumococcal			F0883			

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F0883 SS = D	Continued from page 16 vaccination series as recommended by the Center for Disease Control (CDC), who were reviewed for immunizations. Findings include: R12's quarterly Minimum Data Set (MDS), dated 4/16/26, indicated R12 admitted to the facility on 1/14/26, was 72 years of age, and diagnoses included diabetes and Parkinson's disease. R12's electronic health record (EHR) indicated R12 received PCV13 on 9/25/19, and PPSV23 on 10/22/20. The CDC's Adult Immunization Schedule, dated 10/7/25, indicated for persons 50 years of age and older who previously received both PCV13 and PPSV23, one dose of PCV20 or PCV21 was recommended at least 5 years after the last pneumococcal vaccine dose. R12 was eligible after 10/22/2025. However, R12's EHR lacked evidence that the resident and/or resident representative had been offered, educated on, and/or provided a PCV20 or PCV21 vaccine. During an interview on 7/2/26 at 10:20 a.m., director of nursing (DON) and assistant director of nursing (ADON) confirmed R12 was eligible for a PCV20 or PCV21, and the facility had not offered a PCV vaccine to R12.			F0883			

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K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 06/30/26. At the time of this survey, The Estates at Twin Rivers was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us			K0000			08/03/2026

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 reverse for further 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.

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

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K0000 Bldg. 01	Continued from page 1 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1.A detailed description of the corrective action taken or planned to correct the deficiency. 2.Address the measures that will be put in place to ensure the deficiency does not reoccur. 3.Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4.Identify who is responsible for the corrective actions and monitoring of compliance. 5.The actual or proposed date for completion of the remedy. The Estates at Twin Rivers is a 1-story building with a partial basement was built in 1962 with an addition in 1977 and was determined to be of Type II(111) construction. The facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 45 beds and had a census of 37 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:			K0000			08/03/2026
K0914 SS = C Bldg. 01	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or			K0914	K914 - Electrical Systems - Maintenance and Testing -The process for satisfying this requirement has been reviewed and revised as needed to ensure the resident room electrical receptacle testing is completed. -The Maintenance Director has been educated to the requirement using the regulation -The Maintenance Director will complete and document testing and inspections per the regulation. -To ensure compliance with this requirement, monitoring audits will be completed		08/03/2026

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NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 305 FREMONT STREET , ANOKA, Minnesota, 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
K0914 SS = C Bldg. 01	Continued from page 2 renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct the electrical testing and maintenance per NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.3.2, 6.3.4.1.3, and 6.3.4.2.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/30/2026 at 9:30 AM, it was revealed by a review of available documentation at the time of the survey the facility provided documentation dated 06/19/2026 for resident room electrical receptacle testing and the previous inspection was completed in January 2025. Electrical outlet inspection and testing was not done within the annual timeframe. This deficient finding was confirmed by the Regional Maintenance Director at the time of discovery.			K0914	Continued from page 2 weekly for four (4) weeks, and monthly thereafter for two (2) months. Any deficient practice will be immediately corrected and results will be reported to QAPI. -Maintenance Director or Designee is responsible party -Corrective action will be completed on or before 8/3/26.		08/03/2026



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 13, 2026

Administrator
GLENOAKS SENIOR LIVING CAMPUS
100 GLEN OAKS DRIVE
NEW LONDON, MN 56273

RE: CCN: 245360
Cycle Start Date: June 10, 2026

Dear Administrator:

On June 10, 2026, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

