



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 12, 2025

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

RE: CCN: 245298
Cycle Start Date: May 23, 2025

Dear Administrator:

On May 23, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), 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:

Nikki Harvey, Regional Operations Supervisor

St. Cloud A District Office

Health Regulation Division

Minnesota Department of Health

4140 Thielman Lane

Saint Cloud, Minnesota 56301-4557

Email: nikki.harvey@state.mn.us

Office: (320) 223-7318 Mobile: (320) 216-5631

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 August 23, 2025 (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 November 23, 2025 (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
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 305 FREMONT STREET ANOKA, MN 55303		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments On 5/19/25 through 5/23/25, a survey for compliance with §483.73 Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000			
E 015 SS=C	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.542(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff	E 015			7/3/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/19/2025

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025	
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 305 FREMONT STREET ANOKA, MN 55303			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 015	Continued From page 1 and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to keep at least a three day supply of			E 015	Submission of this Response and Plan of Correction is not a legal admission that a		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025	
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 305 FREMONT STREET ANOKA, MN 55303			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 015	Continued From page 2 emergency food and water on hand to utilize if an emergency would occur and require it. This had the ability to effect all residents, visitors, and staff in the facility at the time of the emergency. findings included. During a tour of the facility with the administrator on 5/22/25 at 11:38 a.m., the storage area for emergency food and water supplies was requested to be visualized but not shown. During an interview on 5/22/25 at 12: 25 p.m., the culinary director (CD) stated the facility just found out they needed to keep extra water on hand in case of an emergency and had started ordering two cases a month until they reached the required amount. The facility was not aware emergency food supplies had to be kept on hand, but there was enough food in the kitchen to provide if an emergency occurred at that time. The CD was unable to say if enough food would be on hand if supply trucks had gotten slowed down or missed on regular delivery days. During an interview on 5/22/25 at 12:28 p.m., the administrator stated the facility should have at least a three day supply of both emergency food and water on hand that can provide for every resident, visitor and staff in the facility at the time of the emergency. Facility policy Emergency Supplies Planning last reviewed 11/24, indicated an adequate supply of emergency food and water would be maintained in appropriate quantities and in accordance with all applicable regulations to accommodate the needs of residents, staff members and visitors for emergency situations. Supplies would be stored			E 015	deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. E015- Subsistence Needs for Staff and Patients Immediate corrective action: Facility obtained a three-day supply of food and water to utilize if an emergency would occur and require it. Corrective action as it applies to others: All residents who reside in the facility have the potential to be affected by this practice. As above, the facility obtained a three-day supply of food and water to		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 305 FREMONT STREET ANOKA, MN 55303		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 015	Continued From page 3 in clearly designated locations and would be easily accessible during crisis or disaster situation.	E 015	utilize in the event of an emergency. Education was provided to the facility administrator and culinary director regarding the emergency preparedness requirement of maintaining a three-day supply of food and water onsite to utilize in the event of an emergency. Date of Compliance: Education and full house audit to be completed by 7/3/25. Reoccurrence will be prevented by: Culinary director or designee will complete a weekly audit x 4 weeks to ensure the facility maintains a three-day supply of emergency food and water onsite. Audits will continue until determined by QAPI to decrease frequency or stop. Corrections will be monitored by the facility culinary director or designee.		
F 000	INITIAL COMMENTS On 5/19/25 through 5/23/25, a standard recertification survey was conducted at your facility. Complaint investigations were also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited. H52984950C (MN00113012) H52984951C (MN00110993) H52984952C (MN00110868) H52984953C (MN00104972) H52984954C (MN00106841) H52984955C (MN00104985)	F 000			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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	Continued From page 4 H52984956C (MN00108707) H52984957C (MN00107148) H52984958C (MN00107711) H52984959C (MN00109017) H52984960C (MN00107998) H52984962C (MN00104771) The following complaint was reviewed: H52984961C (MN00113014) with a deficiency 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 of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000			
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's	F 550			7/3/25

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025	
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 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 550	Continued From page 5 individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to implement interventions to maintain a dignified appearance related to the failure to properly secure urinary leg bags for 1 of 1 residents (R28) reviewed for urinary catheter. Findings include: R28's admission Minimum Data Set (MDS) dated			F 550	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025	
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 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 550	Continued From page 6 2/20/25, indicated R28 had moderate cognitive impairment and required assistance with activities of daily living (ADLs) including dressing, grooming, bathing, and transfers. R28 was noted to have an indwelling catheter. R28's medical diagnoses included an artificial opening of the urinary tract (nephrostomy tubes-tubes which drain urine from the kidneys), benign prostatic hyperplasia (a non-cancerous enlargement of the prostate gland which can lead to various urinary problems in men), renal insufficiency (a condition which the kidneys are not functioning at their full capacity), urinary tract infections, diabetes (a group of diseases which affects how the body uses blood sugar), specialized disorders of the bladder, and dementia. R28's care plan printed 5/21/25, identified R28 was on enhanced barrier precautions related to nephrostomy bag, was a fall risk related to nephrostomy tubes (a tube inserted through the skin directly into the kidney that drains urine when the urine is unable to leave the body normally), had alteration in mobility related to nephrostomy tubes, and had self care deficit related to bilateral nephrostomy tubes. R28's care plan lacked direction as to management of the nephrostomy bags, cares to be provided to the sites, and direction as to securing of nephrostomy bags for resident to maintain dignity and prevent falls. The Group one (1) CNA (certified nursing assistant) work list, updated 5/21/25, identified R28 was dependent with toileting and had nephrostomy tubes. The list lacked any further direction to staff as to how provide cares for the nephrostomy tubes and bags. On 5/19/25, at 3:59 p.m., R28 was observed			F 550	this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. F550- Resident Rights/Exercise of Rights Immediate corrective action: R28 was immediately assessed for proper securement devices to attach residents leg bag appropriately. Proper securement devices were applied to the resident and care sheets and care plan updated. Picture of proper leg bag securement was placed in residents room for facility staff reference. R28 has since discharged from the facility. Corrective action as it applies to others: All other residents that utilize leg bags have the potential to be affected by this practice. At this time there are no other residents who utilize a leg bag residing within the facility. Education was provided to nursing staff		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 550	Continued From page 7 seated in his wheelchair near the Transitional Care Unit (TCU) nurses station. R28 was positioned near the medication (med) cart and the wall. R28 was observed to have a urinary leg bag coming out of his left pant leg laying on the floor, with R28 observed dragging it as he self propelled his wheelchair. NA-A stopped to assist R28, but then stepped away to wash hands as had not been wearing gloves. NA-A requested licensed practical nurse (LPN)-B provide assist to R28. LPN-B proceeded to push the resident NA-A was assisting to her room, leaving R28 near the nurses station with the leg bag on the floor. LPN-B then returned to assist R28 to his room to secure leg bag. On 5/19/25 at 5:17 p.m., an interview was completed with LPN-B, she had assisted R28 to his room and placed his leg bag back on his leg and tightened the strap. LPN-B stated the concern for leg bag being on the floor was related to "bacteria" and "germs". On 5/22/25 at 10:36 a.m., R28 was observed as he received personal cares. NA-B proceeded to secure nephrostomy bags to R28's legs. The band NA-B was using was a wider width, approximately two inches, such as a band used to secure a catheter tube to the upper thigh. NA-B identified when using a leg bag, there were usually straps which threaded through the leg bag, however, these straps were not available. NA-B stated the straps provided were too large for the bags to secure well to R28's legs. NA-B stated the straps did not work well to maintain the leg bag in place, and the leg bags slid down, at times out of pant legs. NA-B stated it was a concern when the leg bags slid down as the bag would pull on the tubes (nephrostomy tubes).	F 550	regarding leg bags and proper securement devices. Date of Compliance: Education and full house audit to be completed by 7/3/25. Reoccurrence will be prevented by: Director of Nursing or designee will complete audits of residents utilizing leg bags weekly x 4 weeks or until determined by QAPI to decrease frequency of audits. Corrections will be monitored by the Director of Nursing or designee.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025	
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 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 550	Continued From page 8 NA-B stated they needed to make sure the (nephrostomy) dressings remained in place and free from drainage. NA-B stated she had asked about different straps, but "this is what they give us." During interview on 5/22/25 at 11:32 a.m., LPN Clinical Coordinator (CC) stated R28's leg bags should be secured properly on his legs and should not be on the floor due to concerns with dignity, as well as concerns for infection control. CC stated the leg bags should be out of view. CC stated it was her expectation if a leg bag was observed to be laying on the floor, they should be immediately assisted to their room to secure the bag properly. CC stated they have tried a variety straps, they have tried to find the best fit. CC stated she was unaware the current strap was not working effectively. During interview on 5/22/25, at 11:50 a.m., director of nursing (DON) stated the urinary leg bag should not be on the floor. DON stated the leg bag should be secured. She added, they typically came with a strap for the top and for the bottom, and stated she was unsure why this was not being used. DON identified concerns for infection control as well as for dignity of the resident. A facility policy, Indwelling Catheter Care Procedure, dated 7/21/23, was provided upon request for care of urinary drainage bag management policy. This policy lacked information as to management of urinary drainage bag, including placement and process to secure, to ensure privacy and dignity. Upon request for a policy for maintaining resident dignity, the facility provided the document			F 550			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 550	Continued From page 9	F 550			
F 552 SS=D	Combined Federal and State Bill of Rights, revised 6/18/19. Within the document, it identified the 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 documented identified the facility must protect and promote the rights of the resident. Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to obtain proper consent for use of psychotropic medications (a drug which affects behavior, mood, thoughts or perception) for 1 of 5 residents (R35) reviewed for	F 552			7/3/25
			Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025	
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 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 552	Continued From page 10 unnecessary medications. Findings include: R35's admission Minimum Data Set (MDS) dated 3/25/25, indicated R35 had impaired cognition. R35 was noted to receive assist with activities of daily living (ADLs) including dressing, grooming, bathing, and mobility. R35's medical diagnoses included unspecified encephalopathy (brain disease, damage, or malfunction which encompasses a range of conditions that could cause brain dysfunction, which might manifest as confusion, memory loss, personality changes, or severe symptoms like coma), cancer, atrial fibrillation (an abnormal heart rhythm which has been known to lead to complications including stroke, blood clots, and heart failure), hypertension (high blood pressure), arthritis (inflammation of joints), dementia, anxiety, depression, visual hallucinations (seeing something that is not there), adjustment disorder with anxiety, chronic pain syndrome, and fibromyalgia (symptoms of widespread chronic pain, headaches, depression and other symptoms). R35's care plan printed 5/22/25, indicated R35 had "alteration in cognition related to confusion, disorientation to place and time. Poor insight to her deficits or cognitive loss. Poor historian. Sundowning type behaviors of crying and calling out. Has decreased in intensity since admission." The problem statement identified R35 had the diagnosis of major neurocognitive disorder, with behavioral disturbance, encephalopathy due to medical illness (various infections), visual hallucinations, and low vision due to retinal pigmentation disease. The care plan directed			F 552	fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. F552- Right to be Informed/Make Treatment Decisions Immediate corrective action: Consent for psychotropic medications was completed with R35. Residents care plan and orders were reviewed and updated appropriately. Corrective action as it applies to others: All other residents receiving psychotropic medications have the potential to be affected by this practice. Full house audit of psychotropic medications and consent forms was completed by nursing. Education was provided to nursing staff		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025	
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 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 552	Continued From page 11 staff to follow recommendations from mental health provider. The care plan lacked indication of medications used to aide with mood state and behavior. R35's Medication Administration Record (MAR), printed 5/20/25, indicated R35 received the following medications: - lorazepam 0.5 milligrams (mg) by mouth one time a day for agitation. Start date of 4/3/25. (benzodiazepines used for anxiety). - lorazepam 0.5 mg by mouth every four hours as needed for anxiety or agitation for six months. Start date 4/3/2025. - risperidone 1 mg by mouth at bedtime for agitation/delirium. Start date of 5/5/25. (antipsychotic- works by changing certain signals in your brain which affect how you feel and act). - risperidone 0.5 mg by mouth two times a day for delirium/ agitation. Start date 5/5/25. R35 was noted to receive Lorazepam on 13 occasions in April, with results marked as effective on 10 of the 13 occasions used. This was noted to be used on two occasions in May (5/9/25, 5/13/25) with effective results on each occasion. The May MAR was reviewed for the dates of 5/1/25-5/20/25. A review of R35's medical record lacked indication informed consent had been received from R35's responsible party upon admission to the facility, as well as with change of medication dosing/frequency. On 5/20/25 at 3:52 p.m., R35 was observed in her room, resting on her bed, with blanket in place. R35 had a visitor in her room, playing her guitar, and singing to resident. Resident was			F 552	regarding the psychotropic medication policy and procedure and receiving consent for medication administration. Date of Compliance: Education and full house audit to be completed by 7/3/25. Reoccurrence will be prevented by: Director of Nursing or designee will complete audits of 5 residents receiving psychotropic medications for proper consent forms weekly x 4 weeks or until determined by QAPI to decrease frequency of audits. Corrections will be monitored by the Director of Nursing or designee.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025	
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 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 552	Continued From page 12 observed to be awake and was interacting with her visitor. During interview on 5/22/25 at 1:46 p.m., the director of nursing (DON) stated completion of an informed consent was typically completed within the first week following admission if a resident was admitted on a psychotropic medication. DON stated this was typically completed by the floor nurse, however, if it had not been completed within that time frame, it was followed up on by either the licensed practical nurse, clinical coordinator (CC) or the DON. DON stated consents were to be obtained when new medications were added, as well as updated when changes were made in dosage and frequency of existing meds. A request was made for the documentation of informed consent for both risperidone and lorazepam, which were unable to be located in the medical record. DON stated she also did not find them uploaded on the record. DON stated it was important to receive informed consent for psychotropic medications, as they are medications which have the potential to have more adverse (negative) side effects than other medications, and it is important to notify the responsible part of the possible side effects. The facility policy, titled Psychotropic Medication Use Policy, created 4/25, identified the facility would a. Obtain informed consent from the resident and/or resident representative and document education, information regarding the medication indication and directions for use, side effects and potential adverse consequences, risks and benefits of the medication and resident choice. b. Discuss any advance directives that the			F 552			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 552	Continued From page 13 resident has formulated to provide care consistent with resident choice. c. The resident and/or responsible party will be notified regarding dose changes. d. This will be documented in the progress notes. e. Consents and any psychotropic medications will be reviewed quarterly at resident care conferences.	F 552			
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f) (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the	F 561			7/3/25

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 561	Continued From page 14 facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the failed to facilitate resident preferences for bathing and meals for 1 of 1 resident (R27) reviewed for choices. Findings include: R27's admission Minimum Data Set (MDS) dated 5/2/25, indicated R27 was cognitively intact. The assessment identified R27 received assistance with activities of daily living (ADLs) including dressing, grooming, bathing, mobility, and incontinence care (managing of bowel and bladder). The MDS identified it was very important to R27 to choose between a tub bath, shower, bed bath, or sponge bath, and somewhat important to choose what clothes she wished to wear. R27's medical diagnoses included multiple sclerosis (MS), malnutrition (an imbalance of energy and nutrients consumed), thrombocytosis (increase platelet count), pseudobulbar affect (a condition characterized by uncontrollable and inappropriate episodes of laughing or crying, often disconnected from person's actual emotion state). R27 received routinely schedule pain medication, as well as availability of additional pain medication as needed. R27's care plan with a print date of 5/21/25, identified R27 had the potential for alteration in nutrition related to MS, severe protein calorie malnutrition and dyspepsia (indigestion). The goal for R27 was for her to meet estimated nutrient needs, and to either maintain weight or gain weight to ideal body weight range. The care plan directed staff to provide diet as ordered by	F 561	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. F561- Self-Determination Immediate corrective action: R27 was interviewed to update residents preferences regarding bathing and dietary choices. R27s care plan and care sheets were updated to reflect these preferences.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025	
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 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 561	Continued From page 15 the provider. Staff were also encouraged to monitor food and fluid intake per facility protocol and encourage adequate fluid intake. The care plan directed staff to offer fluids and snacks between meals. R27's care plan also identified R27 had a self care deficit related to post surgical status, weakness and MS. The goal indicated R27 will accept assistance with self cares and will be dressed, groomed, and bathed per preferences. The care plan directed staff to follow through with instructions provided by occupational therapy. Staff were also directed to provide with assist of one with dressing and bathing. R27's care plan also identified R27 had alteration in mobility related to post surgical status, weakness and MS. The care plan directed staff R27 was to receive physical therapy (PT) as per doctors orders, and instructed staff to follow PT instructions. The care plan indicated R27 was to receive assist with movement in and out of bed and was to receive assist of one with transfers, however lacked further instructions. Although R27's care plan indicated R27 was on enhanced barrier precautions (increase precautions implemented to prevent the spread of infection) related to surgical incisions, the care plan lacked indication as to how the surgical sites were to be managed, additionally lacked any restrictions in showering related to incisions. The Nursing Assistant care sheet dated 5/21/25, indicated R27 was to receive assistance to transfer with an EZ stand (a mechanical lift to aid in transfers) and did not ambulate. The NA care sheet outlined R27 required assist of one with dressing, bathing, toileting, and required set up for grooming and eating. The care sheet provided no additional instructions to staff for provision of care.			F 561	Corrective action as it applies to others: All other residents have the potential to be affected by this practice. Residents were interviewed regarding their bathing preferences and care plans and care sheets were updated to reflect these preferences. All residents were educated on the bistro menu process and how to request alternate meal options if they do not like the main meal that was scheduled to be given. Education was provided to all staff regarding resident rights and preferences. Staff were educated on the placement of the Bistro menus, distribution of the menus, and what to do when a resident requests an alternate meal. Date of Compliance: Education and full house audit to be completed by 7/3/25. Reoccurrence will be prevented by: Director of Nursing or designee will complete audits of 5 residents for shower and dietary preferences weekly x 4 weeks or until determined by QAPI to decrease frequency of audits. Corrections will be monitored by the Director of Nursing or designee.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025	
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 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 561	Continued From page 16 On 5/19/25 at 5:48 p.m., R27 was served her evening meal. Family member (FM)-A was present in room and asked R27 what she was having for supper. R27 stated she was unaware of what she was having for supper, as she had not ordered the meal selection. R27 uncovered plate and stated it was a tuna fish sandwich and she did not wish to eat this. R27 observed the coffee came without sugar and cream, which she has requested be with meals, and there were also no straws on the tray for resident use with all beverages. R27 placed her call light on to request missing items on tray. R27 stated she was unaware of what the food choices were as she had no menu in her room. R27 stated there was an alternate menu available, however, the evening meal must be ordered by 3:00 p.m. in order to receive this. R27 stated she was unsure what alternatives were available or how to order them. R27 stated she had no special diet, and had been struggling with weight loss. R27 stated she was to receive two supplements per day to help nutrition, but was unsure she had received them consistently. R27 was noted to have liquid protein supplement drinks in her room, however, R27 they were brought in for her by her friend. On 5/19/25 at 5:58 p.m. R27 expressed frustration she had not received a bath/shower since she had arrived. FM-A affirmed that R27 had doctor's appointments last week and wished to receive a bath/shower before going to her appointments, however, had not received assistance. R27 stated an unidentified certified nursing assistant (NA) came in to provide assistance with a sponge bath, however, R27 wanted a shower to be able to wash her hair as it had not been washed in the weeks since			F 561			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025	
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 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 561	Continued From page 17 admission. R27 stated the NA "put it down that she refused" her bath. R27 reported when she asked when she could receive a shower, was told she had to wait for the next shower day. R27 stated "Nobody knows how to do a shower." R27 stated neither PT/OT had worked with her regarding the transfer required for completing a bath and shower. FM-A stated R27's hair had not washed since admission and R27 had expressed desire to shower prior to appointments due to lack of bathing since admission, and desire to be clean for medical appointments. On 5/20/25 1:01 p.m., R27 had been delivered her noon meal. R27 stated the tray lacked sugar and cream for coffee, as well as straws to use with her beverages. R27 stated she had requested this from staff however, they had not returned with the items. R27 stated this was the same case with breakfast. A tray slip was observed on resident tray, which identified R27 requested sugar and cream for coffee, and straws for all beverages. R27 stated she was unaware she was scheduled to receive a bath this afternoon, however, stated she would like her hair washed and linens changed. On 5/20/25 at 4:10 p.m., R27 was observed in her room. R27 stated the shower was completed and hair was washed twice. R27 identified the linens were placed back on bed properly, however, noted they had not been changed. On 5/20/25 at 3:49 p.m., an interview was held with both registered dietitian (RD) and regional culinary director (RCD), about availability of menus and the "Bistro option" for alternates. RD stated residents were provided with a regular menu and bistro menu upon admission. RD was			F 561			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 561	Continued From page 18 unsure as to when updated menus were provided to those who remained in their rooms for meals. RD and RCD both stated the Bistro menus were available in the dining room for ordering alternatives. RD was unsure if Bistro menus were delivered to rooms for those who did not dine in the dining room. RD stated if there were specific requests by a resident, this was indicated on the tray slip and these requests should be facilitated by the dietary staff. R27's tray slip was reviewed at time with RD, and it was noted although the preferences/requests were on the dietary slip, it was not identified in the place where it was normally listed. During interview on 5/21/25 at 9:27 a.m., physical therapy assistant (PTA)-A stated she participated in the therapy for R27. At present time, PTA-A stated they were working with R27 on core strength, transfers into and out of bed, and in/out of wheelchair. PTA-A stated they were also working on range of motion (ROM) for lower extremities and joint mobility. PTA-A stated R27 has been an EZ Stand transfer for nursing staff since 4/29/25. Occupational therapist (OT)-A joined the conversation and stated both PT/OT are working with wheelchair positioning. OT-A stated OT-A does not have a specific goals for showers. OT-A stated she had not been informed by nursing staff of any concerns regarding showers, therefore, that had not been part of the therapy plan. During interview on 5/21/25 at 10:08 a.m., the clinical coordinator (CC)-A stated R27 had received assistance to complete bathing on 5/20/25. CC-A stated R27 was unable to complete showers/baths prior to that time related to incisions on her stomach following a	F 561			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 561	Continued From page 19 laparoscopic procedure (A procedure completed with a scope through several small incisions on the abdomen). CC-A stated R27 required clearance from the medical provider because of the laparoscopic incisions. CC-A stated they had offered to complete a shower on an earlier occasion however, R27 had declined the shower related to the time of day. CC-A stated if it is not their shower day, staff were instructed to accommodate the request if we had extra time. CC-A stated she would expect staff would have offered it multiple times until she agreed to it. CC-A stated lack of shower, or washing of hair, for extended time would not feel very good. Residents were assigned a time for bathing/showering based on their room placement. They tried to work with residents a different day/time was requested however, it was not always possible. CC stated she was unaware of any concerns regarding bathing status until resident care conference on 5/15/25. CC stated R27 had received sponge baths since her admission however, she was unsure if her hair was washed. CC stated when there were recommendations for OT/PT this was relayed to staff. CC stated if staff had concerns with provision of care, PT/OT was consulted. CC stated when trays were delivered to residents in their room, it would be her expectation for staff to respond to requests made by residents upon receipt of their tray. During interview on 5/21/25 at 4:54 p.m., the director of nursing (DON) stated baths were scheduled on a weekly basis. This was completed based on their designated time based upon room placement. DON stated if the resident did not care for the time slot, there may be some flexibility in adjusting it, however, that was not	F 561			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025	
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 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 561	Continued From page 20 always possible. DON stated "We try to be flexible but there is only so much wiggle room in that." If a bath was refused, and it was requested on another day, and the aides had time, it may occur, otherwise the next bath/shower would be completed the following week on the routinely scheduled time. Upon inquiring why a shower was not completed for R27, DON stated that if the person had a laproscopic surgery, they would not have a shower if there were restrictions placed per the doctor's orders upon admission or following the procedure. If there were not restricted orders, the individual could receive a shower. A request was made for verification of orders in place upon admission to abstain from showers, however, DON failed to provide order which identified shower restrictions were in place upon admission. Upon review of R27's After Discharge Orders, from 4/28/25, the notes indicated resident had a laparoscopic procedure, however, had not restricted resident from receiving showers A review of the standing orders, filed 5/20/25 electronically, lacked indication for shower restrictions for those with laparoscopic surgical sites. The document did refer to the policy Skin and Wound Management. The document, not labeled with R27's name, was identified as being signed by the provider 2/1/25. A review of the policy, Skin Assessment and Wound Management, dated 2/25 lacked indication as to management of a laparoscopic surgical site. The facility policy, titled Activities of Daily Living (ADL's) Maintain Ability Policy, dated 3/31/23, was			F 561			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 561	Continued From page 21 reviewed. The statement of intent reads as follows: It is the policy of the facility to specify the responsibility to create and sustain an environment that humanizes and individualizes each resident ' s quality of life by ensuring all staff, across all shifts and departments, understand the principles of quality of life, and honor and support these principles for each resident; and that the care and services provided are person-centered, and honor and support each resident ' s preferences, choices, values and beliefs. Upon review of the procedure, the policy indicated: The facility will provide care and services for the following activities of daily living: ... d. Dining-eating, including meals and snacks,... The policy also identified: A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, ...	F 561			
F 577 SS=C	A policy was requested for resident choices and food preferences, but was not received. Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of	F 577			7/3/25

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025	
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 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 577	Continued From page 22 residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure both recertification survey results, as well as additional complaint investigations, were available for review. This had the potential to affect all 32 residents residing in the facility, as well as family, visitors and staff. Findings include: On 5/19/25 at 2:09 p.m., a folder, titled Twin Rivers Survey Results, was observed outside the Social Services office. This folder contained the survey results from the recertification 4/22/24 through 4/24/24. The folder also contained the complaint investigation survey results from 10/17/24, 1/9/24, and 1/21/25. On 5/19/25 at 2:15 p.m., the administrator stated she was responsible for managing the posting of survey results. Administrator stated the complaint investigations were in the file for review. Administrator stated she was aware the 2567 (Formal documentation of the recertification			F 577	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 577	Continued From page 23 process findings, as well as the outcome of the survey investigations) was to be available for review by residents, families, staff and visitors. On 5/21/25 8:08 a.m., licensed social worker (LSW) stated on 5/19/25, she had removed some survey results from the folder prior to writer's review of the folder as she had seen the papers in the folder were in disarray. LSW stated at this time, all of the papers from investigations completed were returned to the administrator for placement in survey results folder. Administrator walked by at that time, and surveyor and administrator returned to the administrator's office for review of the documents. The survey folder was obtained from administrator at that time for comparison to surveys completed, as documented in Aspen Central Office (ACO-an online computerized federal documentation site which contains the surveys completed for facilities, including both recertification and complaint investigations). On 5/21/25, at 8:10 a.m., a review was completed of ACO documentation. The last facility recertification survey prior to this was completed 4/24/24. Upon review of the complaint investigations from the last recertification, it was identified documentation was present in ACO for the following dates: 4/30/24, 6/6/24, 7/30/24, 11/7/24, 10/17/24, 12/18/24, 1/9/25, 1/21/25, 2/18/25, 2/19/25 and 5/1/25. Upon review of the survey results in ACO, it was noted the following investigations had deficiencies cited: 10/17/24, 11/27/24,1/9/25, 1/21/25, 2/18/25, 2/19/25, and 5/1/25. Of these surveys, the survey results were only present in the facility survey folder for the following dates: 10/17/24, 1/9/24, and 1/21/25, as had been noted on 5/19/25, at 2:09 p.m..	F 577	ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. F577- Right to Survey Results/Advocate Agency Info Immediate Corrective Action: The facility posted updated survey results, including complaint investigations, and plans of correction for the past 3 years in a location accessible to residents, families, and staff. Corrective action as it applies to others: All residents, families, visitors and staff have the potential to be affected by this practice. Survey results, including complaint investigations, and plans of correction were placed in a location that is accessible to all parties mentioned above. Education was provided to the facility administrator regarding posting of facility survey results. All staff were educated as to where survey results, including complaint surveys, and plans of correction can be located within the facility. Date of Compliance: Education and full house audit to be completed by 7/3/25. Reoccurrence will be prevented by: Facility administrator or designee will complete audits weekly x 4 weeks to ensure that past survey results, including complaint surveys, and plans of correction		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 577	Continued From page 24 On 5/21/25, at 8:41 a.m. an interview was held in follow up with the administrator. At this time, the adminstrator stated she did not need to have the additional dates provided as had not previously printed out, or placed, any additional survey information in the survey folder aside from what was outlined above. The administrator stated she was aware the 2567's were required to be available for review from all surveys, including recertifications and complaint investigations. An untitled, undated document was received upon request for the policy for posting of survey results. This document, identified as Minnesota Statute § 144A.10, Subdivision 3, mandated that skilled nursing facilities (SNFs) posted correction orders and notices of noncompliance in a conspicuous and readily accessible place within the facility. The document further identified this requirement ensured transparency and allowed residents, families, and the public to be informed about the facility's compliance status. The policy identified facilities were required to post copies of each correction order and notice of noncompliance received after their most recent inspection or reinspection.	F 577	are posted and accessible to residents, families, visitors, and staff. Audits will continue until determined by QAPI to decrease frequency of audits. Corrections will be monitored by the facility administrator or designee.		
F 584 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	F 584			7/3/25

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 584	Continued From page 25 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. 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 consistently provide clean bed linens for 1 of 1 residents (R27) reviewed for choices and provision of assistance with activities of daily living (ADLs).	F 584			
			Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 584	Continued From page 26 Findings include: R27's admission Minimum Data Set (MDS) assessment dated 5/2/25, indicated R27 was cognitively intact. The assessment identified R27 received assistance with ADLs including dressing, grooming, bathing, mobility, and incontinence care (managing of bowel and bladder). R27's medical diagnoses included multiple sclerosis (MS) and malnutrition (an imbalance of energy and nutrients consumed). R27's care plan dated 5/2/25, identified R27 had a self care deficit related to post surgical status, weakness and MS. The goal indicated R27 will accept assistance with self cares and will be dressed, groomed, and bathed per preferences. R27's care plan also identified R27 had alteration in mobility related to post surgical status, weakness and MS. On 5/19/25 at 5:58 p.m., R27 expressed frustration she had not received a bath/shower since she had arrived and expressed frustration regarding lack of change of bed linens. R27 stated she was unsure as to when the bedding had last been changed. R27 routinely remained in bed for meals due to mobility concerns. During interview on 5/20/25 at 1:01 p.m., R27 stated she was unaware she was scheduled to receive a bath this afternoon however, stated she would like her hair washed and linens changed. R27's bottom sheet had come off at the foot of the bed, and linens were noted to have small bread like crumbs and some tannish colored coffee spills on the top sheet. R27 ate all meals sitting in bed due to mobility concerns.	F 584	or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. F584- Safe/Clean/Comfortable/Homelike Environment Immediate Corrective Action: R27 had her bed linens changed. Corrective action as it applies to others: All other residents have the potential to be affected by this practice. Full house audit was completed to ensure that residents had bed linens changed within the past seven days. Residents who refused to have their bed linens changed were verbally educated of the facility process of changing bed linens weekly on bath days and as needed.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 584	Continued From page 27 On 5/20/25 at 3:10 p.m., it was noted R27's bedding was placed back on the mattress and was folded back, however, linens had not been changed, as evidenced of by tannish colored spots on bedding previously observed. On 5/20/25 at 4:10 p.m., R27 was observed back in her room. R27 stated the shower was completed and hair was washed twice. R27 identified the linens were placed back on bed properly, however, noted they had not been changed as the same tannish spots previously noted remained in the same location on the sheets. During interview on 5/21/25 at 10:08 a.m., the clinical coordinator (CC)-A stated linens should have been changed while she was in the shower. CC-A stated linen changes were done routinely on bath days, and in between as indicated if they were soiled. The facility policy, titled Activities of Daily Living (ADL's) Maintain Ability Policy, dated 3/31/23, was reviewed and the statement of intent reads as follows: It is the policy of the facility to specify the responsibility to create and sustain an environment that humanizes and individualizes each resident's quality of life by ensuring all staff, across all shifts and departments, understand the principles of quality of life, and honor and support these principles for each resident; and that the care and services provided are person-centered, and honor and support each resident 's preferences, choices, values and beliefs. The policy lacked information regarding maintaining a clean, hygienic environment for residents, including provision of fresh bath and bed linens.	F 584	Education was provided to all staff regarding changing bed linens weekly on shower days, as needed for soiling, and if requested by the residents. Staff were educated to update nurse leadership if residents are refusing linen changes. Date of Compliance: Education and full house audit to be completed by 7/3/25. Reoccurrence will be prevented by: Director of nursing or designee will complete audits of 5 residents weekly x 4 weeks to ensure that residents have clean linens on their beds. Audits will continue until determined by QAPI to decrease frequency of audits. Corrections will be monitored by the Director of Nursing or designee.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 584	Continued From page 28	F 584			
F 655 SS=D	A facility policy for change of bed linens was requested and was not provided. Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary	F 655			7/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 655	Continued From page 29 of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a baseline care plan was developed to ensure all care needs were adequately addressed for 1 of 1 residents (R29) reviewed for range of motion. Findings include: R29's admission Minimum Data Set (MDS) dated 2/6/25, indicated R29 experienced moderate cognitive impairment. R29 was identified to have functional limitation of range of motion on one side with impairment on one side. R29 required assistance with activities of daily living (ADLs), including dressing, grooming, bathing, and mobility. R29's medical diagnoses included sequelae of cerebral infarction (details of cerebral infarction (stroke-and its effects it can cause to the brain including, but not limited to, change in mobility, loss of movement of one side of the body, vision problems, memory loss and difficulty with problem solving, emotional and behavioral changes, and seizures), heart failure (a condition where the heart is not able to pump enough blood for the body's needs for blood and oxygen), hypertension (high blood pressure), diabetes (a group of diseases which affects how the body	F 655	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 655	Continued From page 30 uses blood sugar), muscle weakness, difficulty in walking and unsteadiness of his feet. A review of R29's medical record was completed. R29 was admitted on 1/31/25 (Friday). R29's 48-hour care plan was initiated on 2/3/25 and locked (no further entries were allowed) on 2/14/25. R29's 48-hour care plan identified the following: Self-care deficit related to L(left) side(d) weakness, impaired vision: The following goals were identified for R29: Resident will accept assistance with self-cares. Resident will be dressed, groomed and bathed per preferences. The following interventions were also identified: Occupational Therapy (OT) per MD (medical doctor) order Follow OT instructions. Assist with bathing with assist of one. Assist with dressing (Specify) [There were no specific interventions identified with this.] Mobility: Alteration in mobility related to left (L) sided weakness and impaired vision. The following goals were identified: Resident will move safely within their environment. The following interventions were outlined: Physical Therapy (PT) per MD order. Follow PT instructions. Assist with ambulation (Specify) [There were no specific interventions identified with this.] Assist with movement in bed and in/out of bed. [There were no specific interventions identified with this.]	F 655	F655- Baseline Care Plan Immediate corrective action: R29s care plan was reviewed and updated to reflect residents current medical conditions, including range of motion deficits. Residents care guide was reviewed for accuracy and updated with current range of motion limitations. Corrective action as it applies to others: All new admissions to the facility have the potential to be affected by this practice. Admissions in the last 30 days were reviewed for appropriate care plans and care guides. Education was provided to nursing staff regarding the 48-hour care plan and the importance of implementing this care plan upon admission to the facility. Date of Compliance: Education and full house audit to be completed by 7/3/25. Reoccurrence will be prevented by: Director of nursing or designee will audit new admissions to ensure that a 48-hour care plan has been completed within 48-hours from admission and ensure that care plans are accurate and complete and that care guides have been updated to reflect residents needs. Audits will be completed on all new admission x 4 weeks and audits will continue until determined by QAPI to decrease frequency or stop. Corrections will be monitored by the Director of Nursing or		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025	
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 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 655	Continued From page 31 Assist with transfers with one to two assist. [The care plan lacked specification whether transfers were to be completed with one or two.] Fall Risk related to (L) side weakness, impaired vision: The following goals were identified: Resident will be safe and free from falls. The following interventions were included: Follow PT and OT instructions for mobility function. Follow resident specific fall prevention plan: (Specify) [There were no specific interventions identified with this.] Monitor and document on safety. Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter/remove any potential causes if possible. Educate resident/family/ caregivers/IDT (Interdisciplinary Team) as to causes. Alteration in elimination: The following goals were identified: Resident will be continent during waking hours. Resident will continue to have at least one (1) continent void daily (qd). Resident will be free from signs/symptoms of UTI (urinary tract infections). [The care plan lacked indication of what symptoms were to be monitored for.] The following interventions were identified: Assist of one (1) with toileting. Provide assistance with peri-cares morning (AM), bedtime (HS) and as needed (PRN). Provide incontinent products and assist to change PRN. Alteration in psychosocial well-being. Resident is			F 655	designee.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 655	Continued From page 32 adjusting to nursing home placement, change in routine, and care needs: The following goals were identified: Resident's psychosocial needs will be met. The following interventions were identified: Will monitor safety concerns and evaluate PRN: smoking, elopement, suicide risk etc.. Will monitor mood state, refer PRN. Will monitor and respond to unmet needs. Alteration in Cognition. On 12/4/24 Resident was psychologically assessed in hospital and was determined that resident has insight deficits in terms of his stroke and function. Resident DX cerebral infraction, hyperlipidemia, type 2 diabetes, essential hypertension, chronic heart failure. The following goals were identified: Resident will communicate his/her basic needs as able. The following interventions were identified: Allow resident time to communicate his/her needs/wants. Document changes in orientation. Alteration in mood and behavior. Resident has hx of visual hallucinations and hx of insomnia. Verbalizes sexual comments to female staff. Refuses medications. DX (diagnosis) cerebral infraction, hyperlipidemia (high level of cholesterol-lipids/fats in the bloodstream, type two (2) diabetes, essential hypertension, chronic heart failure: The following goals were identified: Resident will respond to interventions by staff to calm and redirect. Resident's mood/behavioral state will remain stable. The following interventions were identified:	F 655			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025	
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 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 655	Continued From page 33 MDS section D/PHQ 9 will be conducted per regulation and PRN. Monitor and document mood state/behaviors upon occurrence. Non-Pharm (pharmacological-interventions completed which do not include medications). Inform resident that comments are inappropriate. Change subject to topic related to his family or therapy goals. Redirect prn. Provide emotional support, validation, and comfort measures prn. Resident will have an appropriate discharge plan. Resident will have appropriate discharge plan. Resident is at risk for long term care. Resident diagnosis (DX) cerebral infraction, hyperlipidemia, type 2 diabetes, essential hypertension, chronic heart failure. The following goals were identified for R29: Resident/family will make safe and appropriate decisions regarding d/c (discharge). The following interventions were indicated: Staff will make necessary referrals as needed in order to carry out resident's d/c goals. Resident is categorically a vulnerable adult while resident resides in a Skilled Nursing Facility. Resident is at risk for decreased cognitive and physical abilities related to diagnosis including: cerebral infraction, hyperlipidemia, type two (2) diabetes, essential hypertension, chronic heart failure. The following goal was identified: Resident will remain free from abuse and/or neglect through his next review. The following interventions were identified: Monitor for signs of emotional distress or mood and behavior changes.			F 655			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025	
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 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 655	Continued From page 34 Safety monitoring will be implemented as needed to ensure residents safety (i.e. 15 min checks, 1:1, etc.) Staff will continue to follow the facility vulnerable adult & abuse reporting policy. The local Ombudsman, Adult Protection, Police, and/or state/financial agencies will be notified of any suspected abuse or financial exploitation as needed. R29's MHM 48 Hour Baseline Care Plan, dated 2/1/25, identified several sections to record R29's needs and the care plan interventions which would be provided. However, the following sections of the care plan were left blank and not completed: "Communication" "Nutrition" "Psychotropic Medication Use" "Respiratory" "Skin" "Hospice" "Dialysis" "Smoking" and, "Enhanced Barrier Precautions". The baseline care plan lacked indication R29 was a type two diabetic, with nutritional needs, insulin administration, and lacked instruction to staff for monitoring of blood sugars to be provided by staff. The care plan lacked direction to staff to monitor for signs and symptoms of hyper or hypoglycemia (High or low blood sugar). Additionally, although resident was identified as having visual impairment, the care plan lacked any goals or interventions regarding the impairment itself, only how it may increase potential for falls.			F 655			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 655	Continued From page 35 During interview on 5/23/25 at 1:05 p.m., director of nursing (DON) verified R29's care plan had not been completed within 48 hours. DON stated this was to completed at the time of admission and was to have been completed within that time. This was to completed by the nurse who admitted the resident. DON stated the 48 hour baseline care plan was important and it determined what care was needed by the staff, and directed staff on how to complete the care. A facility policy was requested for the development of a 48-hour care plan, but was not received.	F 655			
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in	F 657			7/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025	
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 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 657	Continued From page 36 disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise resident care plans with updated interventions for 1 of 1 residents (R27) reviewed for choices and activities of daily. Findings include: R27's admission Minimum Data Set (MDS) assessment, dated 5/2/25, indicated R27 was cognitively intact. The assessment identified R27 received assistance with activities of daily living (ADL's) including dressing, grooming, bathing, mobility, and incontinence care (managing of bowel and bladder). The MDS identified it was very important to R27 to choose between a tub bath, shower, bed bath, or sponge bath, and somewhat important to choose what clothes she wished to wear. R27's medical diagnoses included multiple sclerosis, malnutrition (an imbalance of energy and nutrients consumed), thrombocytosis (increase platelet count), pseudobulbar affect (a condition characterized by uncontrollable and inappropriate episodes of laughing or crying, often disconnected from person's actual emotion state). R27 received routinely schedule pain medication, as well as availability of additional pain medication as needed. R27's care plan, print date of 5/21/25, identified			F 657	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. F657- Care Plan Timing and Revision Immediate corrective action: R27s care		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 657	Continued From page 37 R27 had alteration in mobility related to post hysterectomy (surgical removal of uterus), weakness, and MS (multiple sclerosis- a disease that causes breakdown of the protective covering of nerves. Multiple sclerosis can cause numbness, weakness, trouble walking, vision changes and other symptoms). This was initiated on 5/2/25. The care plan directed staff to follow ACP (Associated Clinic of Psychology) recommendation to offer reminders re: her options re: (regarding) transfers and offer of reassurance from staff. The care plan identified R27 was to receive physical therapy (PT) per medical doctor (MD) and to follow PT instructions. Staff were directed to assist with movements in bed and in/out of bed. Staff were directed to assist with transfers with assist of one. The care plan also identified R27 had a self-care deficit related to post hysterectomy, weakness, MS. The goal statement indicated resident will be dressed, groomed and bathed per preferences. The identified R27 was to receive occupational therapy (OT) per MD (medical doctor) and staff were directed to follow OT instructions. The care plan identified R27 was to receive assist of one with bathing and dressing. The care plan lacked information regarding resident's transfer into/out of wheelchair, wheelchair positioning, and amount of time to be up in wheelchair. Although the care plan indicated R27 was to be dressed, groomed, or bathed per preferences, the care plan lacked direction as to what R27 had expressed as her preference. The care plan lacked any direction as to work with R27 with transfers and mobility related to side effects of MS. Additionally, the care plan lacked direction to staff as to how bathing was to be completed, and how dressing changes were to be managed. R27 was admitted after she had undergone a	F 657	plan was reviewed and updated with residents current preferences for activities of daily living. Residents care sheet was also updated with residents current preferences for bathing and transfers. Corrective action as it applies to others: All other residents have the potential to be affected by this practice. All residents were reviewed for transfer status and reinterviewed for bathing preferences. Care plans and care sheets were updated to reflect residents current preferences. Education was provided to all nursing staff regarding comprehensive and timely care planning when a resident has a change in preference or if a resident has a specific preference when it comes to bathing and/or showering. Staff were educated to inform the nurse leadership team when a resident has a change in preferences so that they can be reviewed and care plan and care guide can be updated timely. Date of Compliance: Education and full house audit to be completed by 7/3/25. Reoccurrence will be prevented by: Director of Nursing or designee will complete audits on 5 residents weekly x 4 weeks to ensure that residents care plans and care sheets are updated timely and reflect residents current preferences. Audits will continue until determined by QAPI to decrease frequency of audits or to stop. Corrections will be monitored by the Director of Nursing or designee.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025	
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 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 657	Continued From page 38 laparoscopic hysterectomy and had four small surgical sites which were covered with dressings. A therapy communication from physical therapy, dated 4/29/25, indicated R27 was to be transferred with use of an EZ stand (a mechanical lift used to assist with transfers). The form indicated R27 was to be up in chair three times a day. The nursing assistant care sheet, updated 5/21/25, indicated R27 was to transfer with the EZ stand and did not ambulate. The care sheet also identified R27 received assist of one with dressing, bathing, and toileting. The care sheet indicated R27 received assist for set up for grooming and eating. The care sheet indicated R27 was able to make her needs known. The care sheet lacked direction to assist R27 up in the chair three times a day. The care sheet lacked any information as to any interventions to be implemented to make the transfers and mobility go easier. On 5/19/25 at 5:55 p.m., R27 stated the certified nursing assistants (CNA) don't know how to transfer, position, perform her cares, or move her due to her rigidity. R27 stated the staff were unsure how to transfer her to and from bed/wheelchair. R27 stated she had spastic rigidity (a response when it was difficult to flex joints related to the spasm). R27 stated if allowed time, she was able to relax and move as needed, however, stated were not allowing her the time and moved her quickly, when still displaying rigidity. On 5/21/25 at 9:27 a.m., occupational therapist (OT)-A stated they are working with R27 with			F 657			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025	
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 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 657	Continued From page 39 wheelchair positioning. OT-A stated R27 was to be up in wheelchair daily for quality of life. On 5/21/25 at 10:08 a.m., licensed practical nurse (LPN), clinical coordinator (CC)-A stated physical therapy (PT) evaluated the safe way for R27 to transfer and move. This information was relayed to staff to implement. CC-A stated this information was to be on the care sheet so that staff were aware of how to care for R27. She was uncertain if R27's spastic rigidity was addressed in care plan, or care sheet. R27 was also on medication to help with spasms. CC-A stated most recent care conference was held on 5/15/25. CC-A stated at that time, R27 identified concerns regarding her hair not being washed, and not receiving a shower. Although this was identified on 5/15/25, and implemented on 5/20/25, the care plan and care sheet lacked indication of resident preference for bathing and desire to wash her hair. On 5/21/25 at 4:54 p.m., the director of nursing stated the care plan should be reflect resident preferences, as well as how care was to be delivered. DON stated the care plan was to be updated at the time changes implemented. DON stated this would include recommendations made by physical therapy. DON stated the care conferences were attended by CC-A. DON stated changes made to the care sheets were also to be reflected on the care plan, and should be completed at the same time. The care plan and care sheet should both accurately reflect what cares were to be performed by staff, as they direct staff as to what cares were to be performed. A request for the facility policy for care plan			F 657			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 657	Continued From page 40	F 657			
F 677 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 routine bathing assistance for 1 of 1 residents (R27) reviewed for activities of daily living (ADLs). Findings include: Findings include: R27's admission Minimum Data Set (MDS) dated 5/2/25, indicated R27 was cognitively intact. The assessment identified R27 received assistance with activities of daily living (ADL's) including dressing, grooming, bathing, mobility, and incontinence care (managing of bowel and bladder). The MDS identified it was very important to R27 to choose between a tub bath, shower, bed bath, or sponge bath, and somewhat important to choose what clothes she wished to wear. R27's medical diagnoses included multiple sclerosis (MS), malnutrition (an imbalance of energy and nutrients consumed), thrombocytosis (increase platelet count), pseudobulbar affect (a condition characterized by uncontrollable and inappropriate episodes of laughing or crying, often disconnected from person's actual emotion state). R27 received routinely schedule pain medication, as well as availability of additional pain medication as needed.	F 677			7/3/25

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025	
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 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 677	Continued From page 41 R27's care plan, with a print date of 5/21/25, identified that R27 had a self care deficit related to post surgical status, weakness and MS. The goal indicated R27 will accept assistance with self cares and will be dressed, groomed, and bathed per preferences. The care plan directed staff to follow through with instructions provided by occupational therapy (OT) and physical therapy (PT). Staff were also directed to provide with assist of one with dressing and bathing. R27's care plan also identified R27 had alteration in mobility related to post surgical status, weakness and MS. The care plan indicated R27 was to receive assist with movement in and out of bed and was to receive assist of one with transfers, however lacked further instructions. Although R27's care plan indicated R27 was on enhanced barrier precautions (increase precautions implemented to prevent the spread of infection) related to surgical incisions, the care plan lacked indication as to how the surgical sites were to be managed, additionally lacked any restrictions in showering related to incisions. The Nursing Assistant care sheet dated 5/21/25, indicated R27 was to receive assistance to transfer with an EZ stand (a mechanical lift to aid in transfers) and did not ambulate. The NA care sheet outlined R27 required assist of one with dressing, bathing, toileting, and required set up for grooming and eating. The care sheet provided no additional instructions. On 5/19/25 at 5:48 p.m., R27 and Family member (FM)-A were present in room. R27 expressed frustration she had not received a bath/shower since she had arrived. FM-A affirmed that R27 had doctor's appointments last week and wished to receive a bath/shower before going to her			F 677	F677- ADL Care Provided for Dependent Residents Immediate corrective action: R27 was provided a shower per her preference. R27s care sheet and care plan were updated to reflect residents current preferences. Corrective action as it applies to others: All other residents requiring assistance with bathing have the potential to be affected by this practice. Residents were interviewed regarding their bathing preferences and care plans and care sheets were updated to reflect these preferences. Education was provided to all staff regarding resident rights and preferences. Staff were educated on the resident bathing schedule and what to do if a resident refuses and/or requests a different day or time for their scheduled shower/bath. Date of Compliance: Education and full house audit to be completed by 7/3/25. Reoccurrence will be prevented by: Director of Nursing or designee will complete audits of 5 residents to ensure that they receive their scheduled shower/bath weekly x 4 weeks or until determined by QAPI to decrease frequency of audits. Corrections will be monitored by the Director of Nursing or designee.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025	
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 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 677	Continued From page 42 appointments, however, R27 was not assisted with this. R27 stated a certified nursing assistant (CNA) came in to provide assistance with a sponge bath, however, R27 wanted a shower to be able to wash her hair as it had not been washed in the weeks since admission. R27 stated the CNA "put it down that she refused" her bath. R27 reported when she asked when she could receive a shower, was told she had to wait for the next shower day. R27 stated "Nobody knows how to do a shower." R27 stated neither PT/OT had worked with her regarding the transfer into the shower chair required for completing a bath and shower. On 5/20/25, 1:01 p.m. R27 stated she was unaware she was scheduled to receive a bath this afternoon, however, stated she would like her hair washed. On 5/20/25, at 4:10 p.m. R27 was observed back in her room. R27 stated the shower was completed and hair was washed twice. R27 stated this was the first time her hair had been washed for approximately 3 weeks. During interview on 5/21/25, at 9:27 a.m. the physical therapy assistant (PTA) stated she participated in the therapy for R27. At present time, PTA stated they were working with R27 on core strength. PTA stated they were also working with R27 to be able to transfer into and out of bed, and in wheelchair. OT stated OT did not have a specific goals for showers, as they had not been informed by nursing staff of any concerns regarding showers, therefore, that had not been part of the therapy plan. During interview on 5/21/25, at 10:08 a.m. the			F 677			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 677	Continued From page 43 clinical coordinator (CC)-A stated R27 had received assistance to complete bathing on 5/20/25. CC-A stated R27 was unable to complete showers/baths prior to that time related to incisions on her stomach following a laparoscopic procedure (A procedure completed with a scope through several small incisions on the abdomen). CC-A stated R27 required clearance from the medical provider because of the incisions. CC-A stated staff had offered to complete a shower on an earlier occasion, however, R27 had declined the shower related to the time of day. When asked if they had a second opportunity to receive a shower before the next scheduled bath day, CC-A stated if it was not their shower day, staff were instructed to accommodate the request if they had extra time. CC-A stated she would expect staff would have offered it multiple times until she agreed to it. CC-A stated lack of shower or washing of hair for extended time would not feel very good. CC-A stated residents were assigned a time for bathing/showering based on their room placement. When asked if resident's were allowed to choose an alternate time which worked better for them, CC-A stated they tried to work with residents, however, it was not always possible. CC-A stated she was unaware of any concerns regarding bathing status until resident care conference on 5/15/25. CC-A stated R27 had received sponge baths since her admission, however, she was unsure if her hair was washed. During interview on 5/21/25, at 4:54 p.m. the director of nursing (DON) stated baths were scheduled on a weekly basis. This was completed based on their designation based upon rooms. DON stated if the resident did not care for the slot, there might have been some	F 677			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 677	Continued From page 44 flexibility in adjusting it, however, that was not always possible. DON stated "We try to be flexible but there is (was) only so much wiggle room in that." DON stated if a bath was refused, and it was requested on another day, and the aides had time, it may occur, otherwise the next bath/shower would be completed the following week on the routinely scheduled time. Upon inquiring why a shower was not completed for R27, DON stated that if the person had a lap surgery, they would not have a shower if there were restrictions placed per the doctors orders upon admission. If there were not restricted orders, the individual could receive a shower. A request was made at this time for the specific order restricting showers for R27 from the time of her admission, however, was not provided by the DON. Upon review of R27's abbreviated discharge orders from 4/28/25, there were no orders identified for wound care to laparoscopic sites, or restrictions for showering. Upon review After Discharge Orders, from 4/28/25, the notes indicated resident had a laparoscopic procedure, however, had not restricted resident from receiving showers. A review of the information in this documentation lacked indication of this restriction. A review of the standing orders, filed 5/20/25 electronically, lacked indication for shower restrictions for those with laparoscopic surgical sites. The document did refer to the policy Skin and Wound Management. The document, not labeled with R27's name, was identified as being signed by the provider 2/1/25.	F 677			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 677	Continued From page 45 A review of the policy, Skin Assessment and Wound Management, dated 2/25 lacked indication as to management of a laparoscopic surgical site. A review was made of resident task documentation for bathing was completed upon receipt. During the time frame of 4/28/25 through 5/7/25, there were both daily (times four) and twice daily entries (6) where the response to bathing being entered as NA, indicating not applicable. R27's documentation from 5/8/25 through 5/23, had daily entries of NA on three days, and twice daily entries of NA on 10 occasions. The documentation reflected no entries for 5/20/25, the day R27 received assistance bathing. The documentation lacked any date where resident had been assisted with bathing since her admission of 4/28/25. A follow up interview was completed with CC-A on 5/23/25, at 1:03 p.m. CC-A stated the results NA of the task documentation indicated that staff had not provided R27 with assistance to bath during the periods of 4/28/25-5/23/25 , with the exception of assistance to bathe on 5/20/25.. On 5/23/25, at 1:05 p.m. the director of nursing stated the expectation of assigned tasks was that the staff would complete them as directed. The facility policy, titled Activities of Daily Living (ADL's) Maintain Ability Policy, dated 3/31/23, was reviewed. The statement of intent reads as follows: It is the policy of the facility to specify the responsibility to create and sustain an environment that humanizes and individualizes each resident's quality of life by ensuring all staff,	F 677			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 677	Continued From page 46	F 677			
	across all shifts and departments, understand the principles of quality of life, and honor and support these principles for each resident; and that the care and services provided are person-centered, and honor and support each resident ' s preferences, choices, values and beliefs. Upon review of the procedure, the policy indicated: The facility will provide care and services for the following activities of daily living: a. Hygiene -bathing, dressing, grooming, and oral care... The policy also identified: A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming...				
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure the hospice plan of care had been integrated with the facility care plan for 1 of 1 resident (R35), identified to receive hospice services. Findings include: R35's admission Minimum Data Set (MDS) dated 3/25/25, indicated R35 had impaired cognition.	F 684			7/3/25
			Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025	
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 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 684	Continued From page 47 R35 received assistance with activities of daily living (ADLs) including dressing, grooming, bathing, and mobility. R35's medical diagnoses included unspecified encephalopathy, cancer, atrial fibrillation (an abnormal heart rhythm which has been known to lead to complications including stroke, blood clots, and heart failure), hypertension (high blood pressure), arthritis (inflammation of joints), dementia, anxiety, depression, visual hallucinations (seeing something that is not there), adjustment disorder with anxiety, chronic pain syndrome, fibromyalgia (symptoms of widespread chronic pain, headaches, depression and other symptoms). R35's care plan printed 5/22/25, identified R35 received "Hospice Cares". The care plan directed staff to maintain communication with Hospice and keep them informed of resident's condition as needed. Staff were also directed to keep Hospice informed of any changes in resident's condition. Utilize Hospice Care Standing Orders per policy. Involve Hospice care workers in care conferenc. See Hospice plan of care and visit schedule. On 5/20/25, at 3:52 p.m. R35 was observed at this time, resting on her bed, with blanket in place. Resident had an individual in room, playing guitar, and singing to resident. Resident was awake and interacting with visitor. On 5/21/25 at 5:15 p.m., a review of the Hospice file was completed. It was noted that there were calendars in place in the file to record visits of the various Hospice staff. There was only entries on the March calendar, the other calendars were blank. The calendar from March identified RN (registered nurse) visits were completed on 3/20, 3/24, and 3/27. The calendar lacked any			F 684	this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. F684- Quality of Care Immediate corrective action: R35s care plan was reviewed and updated to ensure that the hospice plan of care was integrated with the facility plan of care. Corrective action as it applies to others: All residents receiving hospice cares have the potential to be affected by this practice. Residents who are receiving hospice had their care plans reviewed and updated to ensure that the hospice plan of care was integrated into the facility plan of care. Education was provided to all staff to ensure that when a resident signs on to hospice that their care plan is updated to integrate the hospice plan of care.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 684	Continued From page 48 indication of visits by others. There were no entries on the calendars labeled for April and May. Additionally, in the Hospice file, there was a document titled Hospice Aide visit log. This document had entries for 3/28, 4/4, 4/10, and 4/17. There were no further entries beyond 4/17. During interview on 5/21/25 at 5:27 p.m., the licensed practical nurse clinical coordinator (CC)-A stated the Hospice nurse was at the facility at least once or twice a week, and checked in with her when she came. CC-A stated the frequency of visits depends on the week. CC-A stated she was unaware of a calendar in the Hospice folder. CC-A stated R35 had a HHA (Home Health Aide) come out, however, was unaware of the frequency, and stated, "I think once a week." CC-A stated there were other therapies which were involved, including music therapy and a Hospice social worker, however, was unaware of a schedule. if there were were questions, staff were to contact Triage for Allina Hospice, which was in the special instructions on the chart. Hospice was invited to the care conferences and did participate in the initial conference for R35. CC-A stated the Hospice care plan would be in the medical record, however, upon review of the Hospice section, CC-A confirmed only the Hospice encounter notes were present. On 5/21/25 5:34 p.m., the director of nursing (DON) reviewed records as identified above, as well as reviewed the medical record for the Hospice care plan. DON confirmed the Hospice care plan was not scanned into the Hospice information section and was not available for review.	F 684	Date of Compliance: Education and full house audit to be completed by 7/3/25. Reoccurrence will be prevented by: Director of Nursing or designee will complete audits of all hospice residents to ensure that their hospice plan of care is integrated with the facilities plan of care weekly x 4 weeks or until determined by QAPI to decrease frequency of audits. Corrections will be monitored by the Director of Nursing or designee.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 684	Continued From page 49 During interview on 5/21/25 at 5:41 p.m., licensed social worker (LSW)-A stated the social worker from Hospice was there to visit "for sure every other week", if not weekly. LSW-A stated she was not notified when Hospice social worker would be coming to visit R35. LSW verified the care plan from Hospice should be filed under Hospice in miscellaneous in the electronic record. LSW-A stated Hospice was invited to care conferences, and did attend the initial care conference. Attempts on 5/22/25 to contact Hospice case manager were not successful. A review of the document Allina Health Hospice and Palliative Nursing Home Agreement Medicare/MA Respite Residential dated May 22, 2014 was completed. The document identified the facility shall coordinate with Hospice in developing a plan of care for Hospice patient. The document indicated the facility will assist with periodic review and modification of plan of care. The document directed that the facility will consult with Hospice, as reasonable necessary, with respect to any modification of the plan of care.	F 684			
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and	F 688			7/3/25

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025	
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 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 688	Continued From page 50 services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide routine assistance with range of motion (ROM) to to improve strength, mobility and improve circulation of left arm for 1 of 1 (R29) reviewed for ROM. Findings include: R29's care plan, dated 2/14/25, indicated R29 was a fall risk related to left side(d) weakness, impaired vision. The care plan directed staff to follow PT (physical therapy) and OT (occupational therapy) instructions for mobility function. The care plan additionally identified R29 had self care deficit related to left sided weakness. The care plan directed staff R29 was to receive OT as ordered by provider. Staff were also directed to follow OT instructions. A review of the Interdisciplinary Team (IDT) Conference notes was reviewed and it was noted in the document dated, 2/13/25, R29 was receiving assist with from therapy for ROM with left arm. A review of the subsequent IDT notes of 3/28/25 indicated The IDT note indicated the nurse practitioner had reviewed swelling in left forearm and ordered a compression wrap for his left arm.			F 688	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. F688- Increase/Prevent Decrease in		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 688	Continued From page 51 At the care conference, family member (FM)-B inquired of use of a sling, however, this was to be used only with transfers to encourage resident to use his left arm. The IDT care conference notes of 5/2/25, identified ongoing concerns with swelling of the left forearm and use of the compression wrap was to be continued, as well as continued use of sling only with transfers. A review of the group two (2) nursing assistant care sheet, updated 5/21/25, indicated R29 had an ROM program. A review of the task list documentation from 4/23/25-5/21/25, directed staff to provide ROM to LUE (left upper extremity): all planes (the extent or limit to which a part of the body can be moved around a joint or a fixed point) one (1) direction ten (10) times each w/ (with) extended hold *signs in room on wall to help staff. Upon review of the documentation, it was noted entries for all dates, with the exception of 4/27, 4/28, and 5/17, indicated NA (not applicable-not performed). On 4/27, 4/28, and 5/17, the notation indicated the amount of repetitions as 5 (five). On 5/19/25 at 3:15 p.m., R29 was observed to be sitting in the wheelchair. His right had was noted to resting in an open position on his lap. R29 was observed to have his left arm, with left hand in an open postion, rested on pillow resting on arm rest/lap. R29 stated he had received therapy, however, stated therapy had stopped. R29 stated staff were to perform exercises, gesturing to the multiple page documents posted to the wall with directions as to what to do, however, stated "no	F 688	ROM/Mobility Immediate corrective action: R29 was assessed for an appropriate range of motion program and care plan and care sheets were updated accordingly. Corrective action as it applies to others: All residents who require a range of motion program can be affected by this practice. Residents who have a range of motion program were evaluated for appropriateness and care plans and care sheets were updated to reflect the current range of motion program. Education was provided to nursing staff regarding range of motion programs and where to find details regarding range of motion activities. Date of Compliance: Education and full house audit to be completed by 7/3/25. Reoccurrence will be prevented by: Director of Nursing or designee will complete audits of 3 residents who require range of motion programs to ensure that programs are being completed as scheduled weekly x 4 weeks or until determined by QAPI to decrease frequency of audits. Corrections will be monitored by the Director of Nursing or designee.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025	
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 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 688	Continued From page 52 one does this." On 5/22/25 at 12:14 p.m., R29 was observed to have a visitor at that time, who was observed as she provided assistance to R29 with range of motion for R29. The resident visitor (RV)-1, who identified herself as a friend, stated she assisted R29 with his exercises when she was here, and indicated she followed the directions on the wall. The visitor indicated they liked to come and make R29's day better. On 5/22/25, at 12:24 p.m., certified nursing assistant (CNA)-D stated cares performed for residents were documented on the tasks listing. CNA-D looked at this and identified R29 was to receive ROM to the left upper extremity, as indicated on the tasks section of the medical record. CNA-D stated that she had not performed this yet today, but planned to perform. On 5/22/25, at 2:35 p.m. and interview was held with CNA-B and CNA-C. CNA-B stated it was rare to complete ROM in general. CNA's B and C both stated the most important tasks were completed, which included feeding assists and showers, however, ROM was infrequently done for the residents assigned. On 5/23/25 at 1:03 p.m., licensed practical nurse (LPN)/clinical coordinator (CC)-A indicated upon review of the task listing for R29, completion of ROM was lacking for all days with the exceptions of 4/27, 4/28, and 5/17. CC-A stated the documentation indicated staff were not completing ROM. CC-A stated it was her expectation that staff should have been completing ROM. CC-A verified the care sheet directed staff to perform the ROM program. CC-A			F 688			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 688	Continued From page 53 stated she was unaware the ROM was not consistently completed. On 5/23/25, at 1:05 p.m. the director of nursing stated she had reviewed the information as documented on the tasks sheet and identified it had not been done often. DON stated it was her expectation that ROM was completed as directed, on a daily basis as outlined. A facility policy, Activities of Daily Living (ADLs)/Maintain Abilities Policy, dated 3/31/23, identified the intent as being: It is the policy of the facility to specify the responsibility to create and sustain an environment that humanizes and individualizes each resident ' s quality of life by ensuring all staff, across all shifts and departments, understand the principles of quality of life, and honor and support these principles for each resident; and that the care and services provided are person-centered, and honor and support each resident ' s preferences, choices, values and beliefs. Within the policy, it was identified under the procedure the following: 1. Based on the comprehensive assessment of a resident and consistent with the resident ' s needs and choices, the facility will provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. 2. The facility will ensure a resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living. The facility policy lacked specific identification as to process/policy for performance of ROM, however, when asked for a more specific policy, the facility stated ROM was addressed within the ADL's policy.	F 688			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025	
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 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 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess and analyze a fall with significant injury for 1 of 2 residents (R11) reviewed for falls. Findings include: R11's minimum data set (MDS) completed for significant change dated 3/5/25, was noted to be cognitively intact and able to communicate her thoughts, needs, and wishes. R11 was identified as using a walker and wheelchair for mobility. R11 received assistance to complete her activities of daily living (ADLS), however, actively participated with cares. R11's medical diagnosis included anemia (low levels of healthy red blood cells or hemoglobin), coronary artery disease (a build up in the walls of the blood vessels which supply blood to the heart), hypertension (high blood pressure), diabetes (a group of diseases which affects how the body uses blood sugar), difficulty in walking/unsteadiness on her feet, muscle weakness, peripheral autonomic neuropathy (nerve damage which affects the system which controls involuntary body functions such blood pressure and heart rate, and weakness. The MDS identified R11 had a history			F 689	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance.		7/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 689	Continued From page 55 of falls with no injury since the last assessment period. R11's Care Areas Assessment, dated 3/5/25, indicated areas to focus on for specialized care included activities of daily living (ADLs-including transfers and mobility), falls, pressure ulcers, pain and use of psychotropic (use of medication affect mood state and behavior) medication. R11's care plan, date of print 5/21/25, identified R11 was a fall risk related to: decreased mobility, psychotropic meds, intermittent confusion, and history of fall. Staff were directed to ensure wheelchair breaks were locked and wheelchair remained close to resident when transferring. R11 was identified as being impulsive at times. Staff were directed to remind R11 to slow down when transferring. This problem statement was identified as being initiated on 4/16/21. The care plan directed staff to monitor and document on safety, as well as review information on past falls and attempt to determine cause of falls. Staff were directed to record possible root causes, and were also directed to remove any potential causes if possible. The care plan directed staff to educate resident/family/caregivers/IDT(interdisciplinary team) as to causes. On 5/19/25 at 5:32 p.m., during interview R11 was seated in wheelchair and was propelling herself into her room. R11 stated everything was going well and reported no concerns to surveyor. On 5/21/25 at 12:49 p.m., R11 was observed walking in the hallway in gripper socks using a rolling walker. R11 was walking with occupational therapist (OT)-A who was bringing wheelchair up	F 689	F689- Free of Accident Hazards/Supervision/Devices Immediate corrective action: R11s fall from 4/30/25 was reviewed and full analysis completed. The care plan and care sheet were updated regarding residents fall intervention. Corrective action as it applies to others: All residents have the potential to be affected by this practice. All resident falls in the past 30 days were reviewed for proper analysis and care plans reviewed for proper interventions. Education was provided to the nursing team regarding implementation of fall interventions and completing a thorough analysis of fall causes. Date of Compliance: Education and full house audit to be completed by 7/3/25. Reoccurrence will be prevented by: Director of Nursing or designee will complete audits of 5 falls to ensure that a thorough analysis was completed and a proper intervention put into place weekly x 4 weeks or until determined by QAPI to decrease frequency of audits. Corrections will be monitored by the Director of Nursing or designee.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025	
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 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 689	Continued From page 56 behind R11. R11 was observed to have abruptly stopped and sat down in wheelchair. OT-A instructed R11 of need to verbalize need/desire to sit down. OT-A did not have the wheelchair brakes on. OT was able to safely assist R11 to a seated position. During record review on 5/19/25 at 7:53 p.m., a progress note, written on 4/30/25 at 2:07 p.m., identified: Resident was sent to hospital after a fall accident with therapy. Res had a cut under left eye and hit on head. A subsequent note from 4/30/25 at 6:43 p.m., identified the head/brain/facial bones and cervical spine were assessed with computerized tomography (CT-an imaging test which helps healthcare providers detect injuries). This was completed related to R11 having experienced a fall with facial injuries. The findings included the following: Head CT: Intracranial contents: No intracranial hemorrhage (bleeding into the brain), extraaxial collection(collections of fluid within the skull, but outside the brain), or mass effect (a space occupying lesion which may increase intracranial pressure, and displace soft tissues of the brain). No CT evidence of acute infarct (tissue death). Chronic lacunar infarcts in the right basal ganglia (small deep infarcts primarily caused by chronic hypertension, atherosclerosis, and diabetes). Mild presumed chronic small vessel ischemic changes (changes related to decrease blood flow). Mild generalized volume loss. No hydrocephalus (build up of fluid in the brain). Head CT: No acute intracranial findings(no hemorrhage, shift, or mass effect). Mild generalized cerebral volume loss and presumed chronic microvascular ischemic changes of the white matter.			F 689			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025	
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 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 689	Continued From page 57 A review of the narrative notes lacked indication of a fall analysis was completed. The initial entry did identify the fall occurred with therapy, however, it lacked further information related to the incident to attempt to determine the root cause or possible interventions to prevent this from recurring in the future. On 5/20/25 at 2:55 p.m., an interview was completed with licensed practical nurse (LPN)/clinical coordinator (CC)-A. Upon review of the electronic record, CC confirmed there were no forms on file to indicate a review of the fall had been completed. CC-A indicated the process was to have included a risk management report. The presence of a risk management report would have triggered her to have completed an Incident Review and Analysis Document. CC-A stated this should have been completed to look at the potential root cause was for the fall, and to place interventions to decrease the potential for having this occur again. On 5/22/25 at 11:57 a.m., the director of nursing (DON) stated upon review of the medical record, there were areas to document on the medication administration record (MAR) to prompt assessment of resident following the fall, however, there was no formalized fall analysis. The DON stated a risk management report should have been completed. DON stated from the risk management report, the CC would complete an Incident Review and Analysis document. This information provided details of the fall to allow for analysis of the incident to look for root cause, and identify potential interventions to be implemented to prevent future falls. DON stated this documentation should have been			F 689			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 689	Continued From page 58 completed at the time of the incident. The facility policy, Fall Prevention and Management, dated 2/2024 identified the purpose of this protocol is to identify residents at risk for falls, implement fall prevention interventions, provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall. The policy identified a Fall Risk Evaluation was completed to identify and document the resident ' s risk factors for falls upon admission, annually, with a significant changed in condition, and as needed. The policy identified after the initial actions after the fall, and stabilization of the resident has been completed, nursing staff will complete an incident review and analysis. The policy identified the staff were to clarify the details of the fall, such as when the fall occurred, where it occurred and what the individual was trying to do at the time the fall occurred. The policy directed nursing staff to try to identify possible or likely causes of the incident. This would refer to resident-specific evidence including medical history, known functional impairments, etc. Staff will monitor and document the resident ' s response to and the effectiveness of interventions put in place to prevent further falls for 72 hours post fall.	F 689			
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or	F 757			7/3/25

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 757	Continued From page 59 §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure adequate monitoring for tardive dyskinesia (TD- a disorder that sometimes develops as a side effect of long-term treatment with neuroleptic (antipsychotic) medications) was implemented for 1 of 5 residents (R35) reviewed for unnecessary medications. Findings include: R35's admission Minimum Data Set (MDS) dated 3/25/25, indicated R35 had impaired cognition. R35 was noted to receive assist with activities of daily living (ADLs) including dressing, grooming, bathing, and mobility. R35's medical diagnoses included unspecified encephalopathy (brain disease, damage, or malfunction which encompasses a range of conditions that could cause brain dysfunction, which might manifest as confusion, memory loss, personality changes, or severe symptoms like coma), cancer, atrial	F 757	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025	
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 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 757	Continued From page 60 fibrillation (an abnormal heart rhythm which has been known to lead to complications including stroke, blood clots, and heart failure), hypertension (high blood pressure), dementia, anxiety, depression, visual hallucinations (seeing something that is not there), adjustment disorder with anxiety, chronic pain syndrome, and fibromyalgia (symptoms of widespread chronic pain, headaches, depression and other symptoms). R35's care plan printed 5/22/25, indicated R35 had "alteration in cognition related to confusion, disorientation to place and time. Poor insight to her deficits or cognitive loss. Poor historian. Sundowning type behaviors of crying and calling out. Has decreased in intensity since admission." R35's diagnoses included major neurocognitive disorder, with behavioral disturbance, encephalopathy due to medical illness (various infections), visual hallucinations, and low vision due to retinal pigmentation disease. The care plan directed staff to follow recommendations from mental health provider. The care plan lacked indication of baseline monitoring for side effects of antipsychotic medication. R35's Medication Administration Record (MAR), printed 5/20/25, indicated R35 received the following medications: - Risperidone 1 milligram (mg) by mouth at bedtime for agitation/delirium. Start date of 5/5/25. Risperidone is a medication classified as an antipsychotic medication. This is a medication that works by changing certain signals in your brain which affect how you feel and act. - Risperidone 0.5 mg by mouth two times a day for delirium/ agitation. Start date 5/5/25.			F 757	ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. F757- Drug Regimen is Free from Unnecessary Drugs Immediate corrective action: Facility nursing staff completed and AIMS assessment on R35 on 5/20/2025 during survey period. No abnormal movements or signs and symptoms of TD were noted during assessment. Corrective action as it applies to others: All other residents receiving antipsychotic medication have the ability to be affected by this practice. An audit was completed to identify residents receiving antipsychotic medication. Any resident who had not had an AIMS assessment completed in the past 6 months was assessed by nursing staff and an AIMS assessment was completed per facility protocol. Education was provided to nursing staff that all residents receiving antipsychotic medication must have an AIMS assessment completed upon admission, every 6 months, after discontinuation of the antipsychotic, and as needed. Date of Compliance: Education and full house audit to be completed by 7/3/25. Reoccurrence will be prevented by:		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 757	Continued From page 61 A review of R35's medical record lacked indication that an Abnormal Involuntary Movement Scale (AIMS) evaluation had been completed. AIMS evaluation was a test developed to measure involuntary movements known as tardive dyskinesia (TD). A request was made for the documentation of AIMS testing for R35, and it was noted by the facility there was no AIMS on resident record, per documentation on the form titled Request for Documentation for Unnecessary Medications. On 5/20/25 at 3:52 p.m., R35 was observed in her room, resting on her bed, with blanket in place. R35 had a visitor in her room, playing her guitar, and singing to resident. Resident was observed to be awake, and was interacting with her visitor. During interview on 5/22/25 at 1:46 p.m., the director of nursing (DON) stated the AIMS evaluation was important to assess if the residents had specific side effects of TD. DON stated this was to be done at the time of admission and every six months for residents receiving antipsychotic medications. DON stated this was last done on 5/20/25, however, had not been completed until after information had been requested by surveyors. The facility policy, titled Psychotropic Medication Use Policy, created 4/25, identified the facility that DISCUS (Dyskinesia Identification System Condensed User Scale) or AIMS testing will be completed at baseline, semi-annually and monthly times 3 upon discontinuation for antipsychotic medications.	F 757	Director of Nursing or designee will complete audits of 5 residents receiving antipsychotic medications for proper AIMS assessments weekly x 4 weeks or until determined by QAPI to decrease frequency of audits. Corrections will be monitored by the Director of Nursing or designee.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025	
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 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 761 F 761 SS=E	Continued From page 62 Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications had both open dates and expiration dates marked on the medications so staff new how long the medications were good for. This had the ability to affect all residents on the transitional care unit (TCU) who received medications. Findings include:			F 761 F 761	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction.		7/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025	
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 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 761	Continued From page 63 On 5/21/25 at 12:21 p.m., a review of the TCU medication care and treatment cart was performed. Three different insulin dial up pens were observed without open dates or expiration dates documented on the pens. Three different inhalers were also observed without open dates or expiration dates. During an interview on 5/21/25 at 12:36 p.m., licensed practical nurse (LPN)-A reviewed the medications and confirmed there were no open dates or expiration dates on the medications. LPN-A could not report when the medications were opened or how long they were good for once the medications were opened. LPN-A did not know how long insulins or inhalers were good for after opened and stated, "I need to check with my supervisor." On 5/22/25 attempts to contact the pharmacy consultant were not successful. During an interview on 5/22/25 at 12:27 p.m., the director of nursing (DON) stated an expectation that medication would be dated with both the open date and expiration date, so staff were aware how long they were good to administer. Administering medication beyond the expiration date could result in the resident responding differently to the medication as the potency may change. A facility policy on dating and disposal of multi-use medication was requested, however, none was provided			F 761	In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. F761- Label/Store Drugs and Biologicals Immediate corrective action: The TCU medication cart was audited for open and expiration dates labeled on all insulin pens and inhalant medications. Medications with no open date were discarded and reordered. Corrective action as it applies to others: All residents residing on the TCU who receive insulin and/or inhalers could be affected by this practice. TCU medication cart was audited as above, and all medications were reviewed for open and expiration dates. Education was provided to nursing staff to ensure that nurses and TMAs label all insulin and inhalant medications when		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 761	Continued From page 64	F 761	opening them and also indicating an expiration date on the medication as needed. Expiration guidelines were placed at each nurses station for reference. Date of Compliance: Education and full house audit to be completed by 7/3/25. Reoccurrence will be prevented by: Director of Nursing or designee will complete audits of one medication cart for unlabeled medications weekly x 4 weeks or until determined by QAPI to decrease frequency of audits. Corrections will be monitored by the Director of Nursing or designee.		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure food served to the residents was palatable, at a pleasing temperature, and in a timely manner for 4 of 4 residents R145, R29, R33, and R93 reviewed for food concerns. Findings include:	F 804			7/3/25

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 804	Continued From page 65 R145's admission Minimum Data Set (MDS) dated 5/19/25, indicated R145 was cognitively intact. R145 was independent with all aspects of eating and was independent with mobility. R145's medical diagnoses included gastroesophageal reflux disease (GERD-acid indigestion) and diabetes (a disease which impacts the body's ability to process sugar in the blood). On 5/19/25 at 2:22 p.m., R145 stated the food was never warm. R145 went on to state she would love a hot meal. R145 stated the coffee was cold and the food was inconsistent. R145 did not indicate she had requested an alternate meal/new plate, or fresh coffee. R29's admission MDS dated 2/6/25, indicated R29 experienced moderate cognitive impairment. The assessment indicated R29 was independent with eating. R29's medical diagnoses included sequelae of cerebral infarction (details of cerebral infarction (stroke-and its effects it can cause to the brain including, but not limited to, change in mobility, loss of movement of one side of the body, vision problems, memory loss and difficulty with problem solving, emotional and behavioral changes, and seizures), heart failure (a condition where the heart is not able to pump enough blood for the body's needs for blood and oxygen), hypertension (high blood pressure), diabetes (a group of diseases which affects how the body uses blood sugar), and muscle weakness. On 5/19/25 at 3:36 p.m., R29 stated today the tray (at noon) was late. R29 stated there should be alternates for food. Today, there were no alternates ready for pork. R29 stated the culinary director went to make something as an alternate	F 804	in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. F804- Nutritive Value/Appear, Palatable/Prefer Temp -The process for satisfying this requirement has been reviewed and revised as needed, to ensure food delivered is palatable, at a pleasing temperature, and in a timely manner. -All residents residing in the facility have the potential to be affected if this regulation is not met. -Culinary staff have received education to the requirement/regulation and training utilizing Monarch Healthcare Management policy and procedure. -Corrective action was addressed with		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 804	Continued From page 66 and provided chickens strips. R29 went on to state the food is late all the time. R33's admission MDS, completed on 3/3/25, indicated R33 had moderate cognitive impairment. R33 was independent with eating. R33's medical diagnoses included hyponatremia (low sodium (salt), a non-cancerous brain tumor, myocardial infarction (heart attack), generalized weakness, and unsteadiness. On 5/19/25 at 5:30 p.m., R33 stated the food is "so-so". R33 commented the alternates available are the same things all the time. The food is not consistently hot, and described the food received with meal trays as "pretty much warm". R33 stated she had not requested staff to warm up the meal tray if received at less than desired temperature. . On 5/19/25 at 11:25 a.m., the culinary director (CD) stated mealtimes at the facility were at 8:00 a.m., 12:00 p.m., and 5:00 p.m. On 5/19/25 at 12:13 p.m., observation was completed in the dining room. Meal service was to begin at 12:00 p.m. At this time, beverages were being served by dietary aide (DA)-A, however, the noon meal had not begun being served. On 5/19/25 at 12:14 p.m., temperature logs were received from 5/16/25 to the present time on 5/19/25 at 12:14 p.m. The culinary services cook (CSC)-A stated she had temped the foods earlier yet had not recorded them. The temperature log reflected no temperatures had been entered for 5/16/24-5/19/25. Upon review of the temperature logs, it was noted from 5/1/25 -5/15/25, there	F 804	residents at resident council. -Compliance audits will be completed weekly x 4 weeks or until determined by QAPI to decrease frequency of audits, with any deficient practice corrected at the time of occurrence. -Culinary Services Director or designee is responsible party. -Corrective action will be completed by 7/3/25.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025	
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 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 804	Continued From page 67 were 11 meals out of 45 where temperatures were not recorded. On 5/19/25 at 12:25 p.m., the first meal was served, 25 minutes after the start of the designated mealtime. Upon initiation of meal service, it was identified there were no alternatives to the pork cutlet served. It was also identified that an alternate meat would need to be prepared as there were three residents who did not consume pork products. CD proceeded to the kitchen to prepare an alternate protein. On 5/20/25 at 12:01 p.m., meal service observation was initiated at this time in the dining room. DA-A was serving beverages to those residents present. At 12:17 p.m., the steam table arrived in the serving kitchen. At 12:24 p.m., it was noted the first meals were served to three residents. At 12:30 p.m., all residents have been served in the dining room. On 5/20/25 at 12:47 p.m., R93 stated "it was a small lunch. Quality and quantity is always small. Timing is (was) always a thing." R93 stated he had enough to eat however, expressed concerns regarding the quality. R93 stated there was often an extended wait for meals. On 5/20/25 at 3:20 p.m., an interview was completed with the Regional Culinary Director (RCD), and Registered Dietitian (RD). RCD stated checking of the temperature of foods, should occur right before the meal was serve, and should be completed with every meal. RCD stated she was surprised there were concerns regarding foods as they used heating pellets to keep the plates warm, heated plates, and domed covers. RCD stated there may be some concerns			F 804			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 804	Continued From page 68 regarding delivery once food was sent out for tray service. RCD stated if the food was reported to be not up to temperature, the food would be either reheated or the resident would be served a new plate. RCD stated she had heard mealtimes have been delayed at times. RCD and RD stated there were routine Food Council meetings to review resident concerns, and stated these meetings were often held on the same day as Resident Council. A request was made for Food Council meeting minutes; however, none were received. A facility policy, titled Meal Times, review 9/2012, identified it was the policy of the facility to serve meals to meet the standards of the surveying agencies, specifying no more than 14 hours between the evening meal of one day and the breakfast meal of the next day. Although the policy included a section which indicated "Meal times will be: " there lacked indicated times for breakfast, noon, and evening. The policy indicated the Hospitality Services Manager was responsible to monitor the system to assure adherence. The policy went on to state all staff were responsible for following this schedule. A facility policy titled Food and Nutrition Services, revised October of 2017, identified "Each resident was provided with a nourishing, palatable, well-balanced diet that met his/her daily nutritional and special dietary needs, taking into consideration the preferences of each resident." The policy identified the meals and/or nutritional supplements would be served within 45 minutes of either resident request or scheduled meal time. The policy also identified "Meal times are posted in the facility common areas."	F 804			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025	
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 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 804	Continued From page 69 A facility policy titled Food Preparation and Service, revised April of 2019, identified proper hot and cold temperatures were maintained during food service. It also identified the temperature of foods held in steam tables were monitored throughout the meal by food and nutrition services staff.			F 804			
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to consistently date fresh and frozen items at the time they were opened, or placed in a container, and failed to remove items which were beyond the acceptable date of use from the refrigerator. The facility also failed to consistently verify the temperatures of freezers			F 812	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other		7/3/25

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025	
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 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 812	Continued From page 70 were within the desired range to assure food integrity and follow through on the temperatures outside of the desired range. The staff also failed to consistently implement the use of hair nets and beard restraints while preparing and serving food. In addition, food temperature monitoring lacked consistency of completion following food preparation and prior to serving. This had the potential to affect all 32 current residents, as well as staff and visitors who ate the food from the kitchen. Findings include: Food storage: On 5/19/25 at 11:31 a.m., the culinary director (CD) reviewed the products of the refrigerator at this time. The CD stated food items should be used within seven days of placing in the refrigerator. The following items were noted to be in the refrigerator and outside of the stated parameters: A five-pound box of bacon, with half of the box remaining was observed to be in an opened paper box which was not sealed. This was removed by the CD. A bottle of lemon juice which was noted to be 32 ounces, with half of a bottle remaining. The manufacturer expiration date was noted to be 3/25. The bottle had been dated on 3/24 as being opened. A stack of sliced cheese, approximately one and a half inches in height, was wrapped in plastic wrap, and was dated 5/8/25. The wrapping was not secured, and one corner of the cheese was opened with cheese crumbling off. The package of cheese was free from mold. The CD removed the cheese from the refrigerator to			F 812	individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. F812- Food Procurement, Store/Prepare/Serve- Sanitary -The process for satisfying this requirement has been reviewed and revised as needed, to ensure food is stored and labeled; hair and beard nets are worn appropriately, along with food temps recorded appropriately. - All residents residing in the facility have the potential to be affected if this requirement is not met. -Food discovered during survey was immediately disposed of; education on use of hair and beard nets was completed, along with food temperatures		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025	
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 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 812	Continued From page 71 be repackaged. A one pound package of butter, was observed to be partially unwrapped, and noted to have approximately half of the block remaining. This was undated. This removed from the refrigerator and disposed of. A six quart container was observed to be in the refrigerator with two quarts of black olives remaining. This was noted to be dated 5/1/25. This was removed from the refrigerator and disposed of. An open package of ham, containing six slices of ham was observed to be dated 5/6/25. This was removed from the refrigerator and disposed of. A one-pound package of bologna, white in color, with watery substance observed at the bottom of the packaging was noted to be dated 3/31/25. This was disposed of. A bag of precooked sausage, dated 5/8/25, was observed to be in the refrigerator. CD stated they had just placed this in the refrigerator on Friday, 5/16/25, however, acknowledged staff would be unaware of the date of 5/8/25 being the date received on delivery and not the date the bag was placed in the refrigerator. CD stated precooked foods could be stored seven days. A sandwich size baggy of chopped up onions was observed in the refrigerator, dated 5/7/25. There was a watery substance at the bottom of the bag, and the onions were soft to touch. This bag was removed and disposed of. On the upper shelf of the refrigerator, there was an undated plastic cup, approximately two ounces in size, of sour cream. This item was removed and disposed of. The dry storage room was surveyed and it was noted to have two onions which had two inches of			F 812	being recorded. - The policy and procedure necessary to meet this requirement was reviewed and revised as needed to ensure food is properly stored, labeled, and staff are aware of the need to both store and dispose of food appropriately, along with how to wear hair nets and temp food appropriately. - Education for culinary staff has been initiated utilizing Monarch Healthcare Management policy and procedures. -Compliance audits will be completed weekly x 4 weeks or until determined by QAPI to decrease frequency of audits, with any deficient practice corrected at the time of occurrence. - Culinary Director or designee is responsible party. - Corrective action will be completed on or before 7/3/25.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 812	Continued From page 72 green sprouts out of the top of them. The onions were noted by the CD to be soft and spoiled and were disposed of. A review of the food items in the freezer was completed and the following was identified. Within the freezer, there was noted to be two chunks of ham in a plastic bag, dated 5/14/25, which CD noted to weigh approximately one and a half pounds which had a large amount of ice crystals surrounding the chunk of ham and laying in the bottom of the bag. A second bag of ham was also noted to be in a plastic bag, covered with many crystals, both on the ham and in the bottom of the bag. This bag was measured at three pounds. CD stated she was unsure if the ham was not cooled down properly to cause formation of ice crystals. Both bags of ham were removed and disposed of. A four-pound bag of fully ice encrusted fajita blend vegetables was observed. This contained a pepper and onion mix. This was not opened and undated. This was removed and disposed of. A review of other frozen vegetables was completed with no other vegetables noted to be encased with ice. A bag of chili sauce was found thawed in freezer, with a date of being opened as 5/13/25, however, was not frozen. The bag was noted to weigh was almost three pounds. CD was unsure why this would have been dated 5/13/25, and yet be thawed to touch. On 5/20/25 at 3:20 p.m.,Regional Culinary Director (RCD) stated foods are dated upon arrival/receipt. RCD stated food products should then be dated with date opened. RCD stated if the food product was a cooked product, it was to be used within three days. RCD stated if it was	F 812			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025	
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 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 812	Continued From page 73 cheese, it was to be discarded after seven days. Ham was to be disposed of within seven days. A facility policy, Food Receiving and Storage, revised October 2017, identified foods were to be received and stored in a manner that complied with safe food handling practices. The policy indicated all foods stored in the refrigerator or freezer were to be covered, labeled, and dated ("use by" date). Although the policy identified to products were to be dated, it lacked definition as to what the time frames were for the food products to be used by, with the exception being that beverages must be dated when opened and discarded after twenty four hours. A policy titled Refrigerators and Freezers, undated, indicated the facility will ensure safe refrigerator and freezer maintenance, temperature and sanitation, and will observe food expiration guidelines. The policy stated all food shall be appropriately dated to ensure proper rotation by expiration dates. "Received" dates (dates of deliver) will be marked on cases and on individual items removed from cases for storage. "Use by" dates will be completed with expiration dates on all prepared foods in the refrigerators. Expiration dates on unopened food will be observed and "use by" dates indicated once food is opened. All expired items were to be discarded. Although the policy addresses the "use by" date, the policy lacks specifications to what the parameters are to be used for determining the "use by date". Monitoring of freezer temperatures: On 5/19/25 at 12:04 p.m., a review was completed of the freezer temperature log for			F 812			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 812	Continued From page 74 freezer A. The log indicated the temperature was to be less than zero degrees, if temperature was higher than zero the staff were directed to contact the culinary manager ASAP (as soon as possible). Upon review of the log, it was noted the temperature was identified as being greater than zero degrees Fahrenheit on four occasions: on 5/12/25, the temperature was recorded as 2.6, on 5/13/25, the temperature was recorded as 2, on 5/14/25, the temperature was recorded as 13.5 degrees Fahrenheit. The log was noted to lack temperature monitoring in the afternoon on four dates (5/14/25, 5/15/25, 5/16/25, 5/18/25) CD stated she was unaware of the freezer temperature being greater than zero degrees. CD stated when the temperature was greater than zero degrees, the staff were to report this to the CD and follow up was to be initiated with maintenance. On 5/20/25 at 3:31 p.m., RCD stated the freezer at the time the temperature was out of range on the freezer, it may have been going under a defrost. RCD stated the temperature was to be monitored on the inside of the freezer. RCD stated she had reviewed the log. RCD stated when irregularity was noted, staff were to allow the freezer to cycle through and go back and recheck the temperature. RCD stated if the abnormality persisted, the CD was to follow up with maintenance, or other departments as indicated. A policy titled Refrigerators and Freezers, undated, indicated the facility will ensure safe refrigerator and freezer maintenance, temperature and sanitation, and will observe food expiration guidelines. The policy outlined that the temperatures of the freezer was to have been	F 812			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025	
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 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 812	Continued From page 75 less than zero degrees Fahrenheit. The policy directed the supervisor to take immediate action if temperatures were out of range. Actions needed to correct the temperatures were to be recorded on the tracking sheet, including the repair personnel and/or department contacted. Hair nets and beard restraints: On 5/19/25 at 12:18 p.m., CD was observed to wearing a hair net; however, the sides of her hair were not completely contained within the hair net. CD was observed with hair net not partially covering her hair in the kitchen, and in the serving kitchen. On 5/20/25 at 12:26 p.m., RCD was observed in the serving kitchen. Although RCD was observed to have a hair net in place, it lacked coverage of her bangs, which were noted to be uncovered on her forehead. On 5/20/25 at 3:43 p.m., registered dietitian (RD) stated hair nets were to be worn in the kitchen, and outside of the kitchen when serving food. RD stated hair nets were to be worn so it covered all of the person's hair. Hair was to be tucked in, no matter what part of your hair it was. On 5/20/25 at 3:47 p.m., RDC acknowledged her bangs were not covered up by her hairnet and stated "I know better." On 5/20/25 at 5:13 p.m., dietary assistant (DA)-B, was observed placing tablecloths on serving tables in the dining room. DA-B's hair was observed to be braided and pulled back away from her face, however, there were areas around			F 812			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025	
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 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 812	Continued From page 76 forehead and ears where the hair net was not restraining/containing the hair. Upon interview, DA-B stated she was unaware her hair was outside of the hair net, and stated it was important for hair nets to be used so that the hair would not get into the food. On 5/21/25 at 4:45 p.m., DA-C was observed in the dining room setting up tables for the evening meal. DA-C was observed to have a hair net in place to cover his head, however, DA-C was also observed to have facial hair present with a light mustache and beard. DA-C was not wearing any facial hair restraint at this time. On 5/21/25 at 4:55 p.m., RDC was observed walking by at the time DA-C was preparing the dining room. Surveyor inquired of RDC if DA-C typically used a facial hair restraint? RDC stated, "He typically does, for sure." 5/21/25 at 4:59 p.m., RDC approached surveyor and stated she had followed up on use of beard nets at the facility. RDC stated the facility lacked beard nets in house. RDC stated in the interim, DA-C would cover face with a face mask. A facility policy, Food Preparation and Service, revised April of 2019, identified under Food Service/Distribution that "Food and nutrition services staff (were to) wear hair restraints (hair net, hat, beard, restraint, et.) so hair does not contact food. Temperature monitoring of meals served: On 5/19/25 at 12:14 p.m., temperature logs were received from 5/16/25 to the present time on 5/19/25 at 12:14 p.m. The culinary services cook (CSC)-A stated she had temped the foods earlier			F 812			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025	
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 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 812	Continued From page 77 yet had not recorded them. The temperature log reflected no temperatures had been entered for 5/16/24-5/19/25. Additional logs were requested from the CD from the start of the month. Upon review of the temperature logs, it was noted from 5/1/25 -5/15/25, there were 11 meals out of 45 where temperatures were not recorded. CD stated the temperatures were to be checked prior to serving the meals, and indicated the temperatures were to be logged immediately after they are checked. On 5/20/25 at 3:32 p.m., RCD stated staff were to check the temperature of foods right before the meal was served. RCD stated there were interventions to maintain food temperatures which included heating pellets, heating plates, domed plates. If the food was not maintaining the desired temperature, her concern would be related to the delivery process, function of the steam table being on, and equipment being efficiently used. A facility policy titled Food Preparation and Service, revised April of 2019, identified under Food Preparation, Cooking and Holding Time/Temperatures that food thermometers used to check food temperatures were clean, sanitized, and calibrated for accuracy. The policy identified under Food Service and Distribution, that the proper hot and cold temperatures were maintained during food service. The policy indicated the temperature of foods held in steam tables were monitored throughout the meal by food and nutrition services staff. The policy lacked definition as to when the temperatures were to be initially taken prior to meals, and the parameters when the temperatures are to be rechecked.			F 812			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 305 FREMONT STREET ANOKA, MN 55303		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 880 F 880 SS=F	Continued From page 78 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 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;	F 880 F 880			7/3/25

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025	
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 305 FREMONT STREET ANOKA, MN 55303			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 880	Continued From page 79 (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 record review the facility failed to ensure urinary leg bags were effectively secured to prevent falling on the floor and being rolled over by wheelchair for 1 of 1 residents (R28) reviewed for urinary catheter. In addition, the facility failed to conduct ongoing surveillance for the infection control program to ensure tracking and trending of symptomatic illnesses not on antibiotics in the facility. This			F 880	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025	
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 305 FREMONT STREET ANOKA, MN 55303			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 880	Continued From page 80 deficient practice had the potential to affect all 32 residents currently residing in the facility. Findings include: R28's admission Minimum Data Set (MDS) dated 2/20/25, indicated R28 had moderate cognitive impairment and required assistance with activities of daily living (ADL's) including dressing, grooming, bathing, and transfers. R28 was noted to have an indwelling catheter. R28's medical diagnoses included an artificial openings of the urinary tract, benign prostatic hyperplasia (a non-cancerous enlargement of the prostate gland in men which can lead to various urinary problems in men), renal insufficiency (a condition which the kidneys are not functioning at their full capacity), urinary tract infections, diabetes (a group of diseases which affects how the body uses blood sugar), specialized disorders of the bladder, and dementia. R28's care plan printed 5/21/25, identified R28 was on enhanced barrier precautions related to nephrostomy bag, was a fall risk related to nephrostomy tubes (a tube that drains urine from the bladder when the urine is unable to leave the body normally), had alteration in mobility related to nephrostomy tubes, and had self care deficit related to bilateral nephrostomy tubes. R28's lacks direction as to management of the nephrostomy bags, cares to be provided to the sites, and direction as to securing of nephrostomy bags for resident to maintain dignity, provide good infection control practices, and prevent falls. The Group one (1) CNA (certified nursing assistant) work list, updated 5/21/25, identified R28 was dependent with toileting and had			F 880	In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. F880- Infection Prevention and Control Immediate corrective action: R28 was provided with the proper securement devices for his urinary catheter leg bags and bags were attached appropriately. R28 has since discharged from the facility. The facility implemented a daily tracking system to include during their IDT meeting to track resident who were experiencing signs/symptoms of illness who were not on antibiotics. Corrective action as it applies to others: All residents who utilize catheter leg bags and all residents who reside at the facility have the potential to be affected by this practice. No other residents that reside at the facility are currently utilizing leg catheter bags. A tracking tool was		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025	
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 305 FREMONT STREET ANOKA, MN 55303			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 880	Continued From page 81 nephrostomy tubes. The list lacked any further direction to staff as to how provide cares for the nephrostomy tubes and bags. On 5/19/25 at 3:59 p.m., R28 was observed next to the Transitional Care Unit (TCU) nurses station. R28 was positioned between the medication (med) cart and the wall, allowing room for wheelchairs to pass. R28 was observed to have urinary leg bag dragging below the left leg of his pants, with urinary leg bag laying on the floor. R28 was observed to moving in a back and forth motion and was observed to roll over his leg bag with the wheel of the wheel chair. Certified nursing assistant (CNA)-A was observed to walk by, pushing another resident. CNA-A observed R28's leg bag on the floor and went to correct this. CNA-A then stated to licensed practical nurse (LPN)-B she needed to help R28, and advised LPN-B to get gloves. CNA-A proceed to step away from residents to go and wash her hands. LPN-B proceeded to propel the resident CNA-A had been assisting to their room. While R28 was left unattended, he proceeded to roll back over the leg bag, which remained on the floor. LPN-B then returned and assisted R28 to his room. CNA-A returned to the nurses station after washing her hands, and stated she had observed R28's leg bag caught in the wheelchair, and that was why she stopped to help. CNA-A stated when she assisted R28, she was not wearing gloves, so needed to wash her hands. CNA-A stated she alerted LPN-B, who was at the medication cart, to provide assistance while she washed her hands. On 5/19/25 at 5:17 p.m., a follow-up interview was completed with LPN-B. LPN-B stated she had assisted the resident being pushed by CNA-A			F 880	developed to track signs/symptoms of illness within the facility daily during IDT and clinical meeting. Education was provided to nursing staff regarding the proper securement devices to utilize with catheter leg bags. All staff were educated regarding tracking resident illness even when resident was not utilizing an antibiotic. Date of Compliance: Education and full house audit to be completed by 7/3/25. Reoccurrence will be prevented by: Director of Nursing or designee will complete audits of residents utilizing catheter leg bags and the completion of the resident illness tracker weekly x 4 weeks or until determined by QAPI to decrease frequency of audits. Corrections will be monitored by the Director of Nursing or designee.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 305 FREMONT STREET ANOKA, MN 55303		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 880	Continued From page 82 to their room, and then returned to the nurses station to help R28. LPN-B stated she assisted R28 to his room, and assisted with placement of leg bag, and tightened his leg band. LPN-B stated she had seen the leg bag on the floor. LPN-B stated with the leg bag being on the floor, there would be the exposure to "bacteria, germs" and added that was why she had fixed it. On 5/22/25 at 10:36 a.m., R28 was observed as he received personal cares. CNA-B proceeded with cares wearing a gown and gloves as required for cares. CNA-B was observed with appropriate infection control practice of hand hygiene and glove use. CNA-B proceeded to secure nephrostomy bags to R28's legs. The band CNA-B was using was a wider width strap, approximately two inches wide, such as a band used to secure a catheter tube to the upper thigh. CNA-B identified when using a leg bag, there were usually straps which threaded through the leg bag, however, these straps were not available for use. Upon observation of the leg bags, it was noted the area on the leg bag where straps would be threaded through had not been used. CNA-B stated the straps provided were too large for the bags to secure well to R28's legs. CNA-B stated she had asked about different straps, but "this is what they give us." CNA-B stated the problem with positioning of the leg bags is related to how they sit on his legs. CNA-B then strapped leg bag to just below the knee, securing the large band at the top of the leg bag. There was no strap available to secure the bottom of the leg bag to the leg. During interview on 5/22/25 at 11:32 a.m., LPN Clinical Coordinator (CC)-A stated R28's leg bags should be secured properly on his legs and	F 880			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025	
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 305 FREMONT STREET ANOKA, MN 55303			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 880	Continued From page 83 should not be on the floor due to concerns with dignity, as well as concerns for infection control, adding it was a "sanitary issue." CC-A stated if the leg bag was laying on the floor, and run over by the wheelchair, there was a potential for the nephrostomy tubes to be pulled out or displaced. CC-A stated it was her expectation if a leg bag was observed to be laying on the floor, they were to be immediately assisted to their room to secure the bag properly. CCA stated they have tried a variety straps they have tried to find the best fit. CC-A stated she was unaware the current strap was not working effectively. During interview on 5/22/25, at 11:50 a.m., director of nursing (DON) stated the urinary leg bag should not be on the floor. DON stated the leg bags were to be secured, adding they typically came with a strap for the top and for the bottom, and stated she was unsure why this was not being used. DON identified concerns for infection control if the leg bag was observed to be laying on the floor. DON stated the leg bag should have been checked/changed. DON stated the leg bag was to be secured to the leg. DON stated the leg bags typically come with straps and they were to be used to secure the leg bags to the leg. DON stated this was important to prevent the tubes from being pulled/tugged on, as well as the potential for the leg bag from being on the floor. A facility policy, Indwelling Catheter Care Procedure, dated 7/21/23, was provided upon request for a policy for care and management of urinary drainage bags. This policy lacked information as to management of urinary drainage bag, including placement and process to secure, to ensure privacy, dignity, and prevention of opportunity for contamination.			F 880			

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: M6TJ11 Facility ID: 00866 If continuation sheet Page 85 of 88

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025	
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 305 FREMONT STREET ANOKA, MN 55303			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 880	Continued From page 85 notified when there was a call in. Sometimes, staff called into the facility and other times they called the administrator directly. The facility did ask why a person was calling in sick but did not require them to report symptoms for the purpose of tracking and trending. I would report to the DON symptoms that I felt might affect the resident and the facility but did not meet with her regularly to discuss all symptoms. Facility policy Infection Prevention and Control Program last revised 11/24 indicated surveillance tools were used to recognize the occurrence of infections, recording their number and frequency, detected outbreaks and epidemics, monitored employee infections, and detected unusual pathogens with infection control implications. Data gathered during surveillance would be used to oversee infections and spot trends.			F 880			
F 912 SS=F	Bedrooms Measure at Least 80 Sq Ft/Resident CFR(s): 483.90(e)(1)(ii) §483.90(e)(1)(ii) Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide 80 square feet of floor space per resident in 8 of 39 rooms (room #s 4,7,17,20, 21, 29, 35 and 36) which affected seven residents (R144, R92, R27, R5, R192, R21, and R2) who currently resided in these rooms. Findings include: During the entrance conference on 5/19/25 at			F 912	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute		7/3/25

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025	
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 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 912	Continued From page 86 11:34 a.m., the facility administrator stated there had been no changes in resident room sizes, and there were waivers in place for room numbers: 4,7,17, 20, 21, 29,35, and 36 which did not meet the required minimum square footage. The following double resident rooms did not meet the required minimum square footage per resident: Room 4 = 150 square feet, or 75 square feet per resident (empty). Room 7 = 152.5 square feet, or 76.25 square feet per resident (R144). Room 17 = 150 square feet or 75 square feet per resident (R92). Room 20 = 150 square feet or 75 square feet per resident (empty). Room 21 = 150 square feet or 75 square feet per resident (R27). Room 29 = 150 square feet or 75 square feet per resident (R5). Room 35 = 150 square feet or 75 square feet per resident (R192, R21). Room 36 = 150 square feet or 75 square feet per resident (R2). Interview on 5/22/25 at 8:35 a.m., R92 stated she did not have a roommate at that time, but she had roommates before. Resident stated the size of the room was not an issue. She did not believe past roommates had complaints about the room size or functionality either. Interview on 5/22/25 at 8:53 a.m., Administrator confirmed one of the waived rooms had two residents in it. Administrator stated the facility planned to keep these rooms available for double occupancy if needed based on census. Administrator provided list of rooms with waivers			F 912	an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. F912- Bedrooms Measure at least 80 Sq Ft/resident June 19, 2025 To whom it may concern, The Twin Rivers Estates has 8 rooms that do not comply with regulation, F912. To ensure patient safety the facility will assess, and review patient needs to ensure the room is appropriate. Each resident admitted will be assessed for equipment needs, transfer status, and any additional clinical needs. The facility is requesting a waiver for the following rooms below; Room #: Dimensions: Total Square Feet: 4 15`3 x 10` 150 sq. ft		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 912	Continued From page 87 dated 4/28/25, it included room numbers, measurements, and square footage of each of the eight rooms.	F 912	7 14` x 10`4 140 sq. ft 17 15`3 x 10`4 150 sq. ft 20 15`3 x 10`4 150 sq. ft 21 15`3 x 10`4 150 sq. ft 29 15` 1 x 10` 4 150 sq. ft 35 10`3 x 14` 4 140 sq. ft 36 15`2 x 10` 4 150 sq. ft Thank you for your consideration; Emily Beseman Administrator The Estates at Twin Rivers		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 12, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: M6TJ11

Dear Administrator:

The above facility was surveyed on May 19, 2025 through May 23, 2025 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:

Nikki Harvey, Regional Operations Supervisor
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: nikki.harvey@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

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 feel free to call me with any questions.

Sincerely,



Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00866	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 5/19/25 through 5/23/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

06/19/25

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00866	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 identify the date when they will be completed. The following complaints were reviewed with no deficiency issued: H52984950C (MN00113012) H52984951C (MN00110993) H52984952C (MN00110868) H52984953C (MN00104972) H52984954C (MN00106841) H52984955C (MN00104985) H52984956C (MN00108707) H52984957C (MN00107148) H52984958C (MN00107711) H52984959C (MN00109017) H52984960C (MN00107998) H52984962C (MN00104771) The complaint H52984961C (MN00113014) which was found to be out of compliance and issued at (TAG) at the time of the survey, remained out of compliance. 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 surveyors 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	2 000			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00866	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html 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. 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.	2 000			
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B.	2 570			7/3/25

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00866	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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
2 570	Continued From page 3 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise resident care plans with updated interventions for 1 of 1 residents (R27) reviewed for choices and activities of daily. Findings include: R27's admission Minimum Data Set (MDS) assessment, dated 5/2/25, indicated R27 was cognitively intact. The assessment identified R27 received assistance with activities of daily living (ADL's) including dressing, grooming, bathing, mobility, and incontinence care (managing of bowel and bladder). The MDS identified it was very important to R27 to choose between a tub bath, shower, bed bath, or sponge bath, and somewhat important to choose what clothes she wished to wear. R27's medical diagnoses included multiple sclerosis, malnutrition (an imbalance of energy and nutrients consumed), thrombocytosis (increase platelet count), pseudobulbar affect (a condition characterized by uncontrollable and inappropriate episodes of laughing or crying, often disconnected from person's actual emotion state). R27 received routinely schedule pain medication, as well as availability of additional pain medication as needed. R27's care plan, print date of 5/21/25, identified R27 had alteration in mobility related to post hysterectomy (surgical removal of uterus), weakness, and MS (multiple sclerosis- a disease that causes breakdown of the protective covering of nerves. Multiple sclerosis can cause	2 570	Corrected.		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00866	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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
2 570	Continued From page 4 numbness, weakness, trouble walking, vision changes and other symptoms). This was initiated on 5/2/25. The care plan directed staff to follow ACP (Associated Clinic of Psychology) recommendation to offer reminders re: her options re: (regarding) transfers and offer of reassurance from staff. The care plan identified R27 was to receive physical therapy (PT) per medical doctor (MD) and to follow PT instructions. Staff were directed to assist with movements in bed and in/out of bed. Staff were directed to assist with transfers with assist of one. The care plan also identified R27 had a self-care deficit related to post hysterectomy, weakness, MS. The goal statement indicated resident will be dressed, groomed and bathed per preferences. The identified R27 was to receive occupational therapy (OT) per MD (medical doctor) and staff were directed to follow OT instructions. The care plan identified R27 was to receive assist of one with bathing and dressing. The care plan lacked information regarding resident's transfer into/out of wheelchair, wheelchair positioning, and amount of time to be up in wheelchair. Although the care plan indicated R27 was to be dressed, groomed, or bathed per preferences, the care plan lacked direction as to what R27 had expressed as her preference. The care plan lacked any direction as to work with R27 with transfers and mobility related to side effects of MS. Additionally, the care plan lacked direction to staff as to how bathing was to be completed, and how dressing changes were to be managed. R27 was admitted after she had undergone a laparoscopic hysterectomy and had four small surgical sites which were covered with dressings. A therapy communication from physical therapy, dated 4/29/25, indicated R27 was to be transferred with use of an EZ stand (a	2 570			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00866	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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
2 570	Continued From page 5 mechanical lift used to assist with transfers). The form indicated R27 was to be up in chair three times a day. The nursing assistant care sheet, updated 5/21/25, indicated R27 was to transfer with the EZ stand and did not ambulate. The care sheet also identified R27 received assist of one with dressing, bathing, and toileting. The care sheet indicated R27 received assist for set up for grooming and eating. The care sheet indicated R27 was able to make her needs known. The care sheet lacked direction to assist R27 up in the chair three times a day. The care sheet lacked any information as to any interventions to be implemented to make the transfers and mobility go easier. On 5/19/25 at 5:55 p.m., R27 stated the certified nursing assistants (CNA) don't know how to transfer, position, perform her cares, or move her due to her rigidity. R27 stated the staff were unsure how to transfer her to and from bed/wheelchair. R27 stated she had spastic rigidity (a response when it was difficult to flex joints related to the spasm). R27 stated if allowed time, she was able to relax and move as needed, however, stated were not allowing her the time and moved her quickly, when still displaying rigidity. On 5/21/25 at 9:27 a.m., occupational therapist (OT)-A stated they are working with R27 with wheelchair positioning. OT-A stated R27 was to be up in wheelchair daily for quality of life. On 5/21/25 at 10:08 a.m., licensed practical nurse (LPN), clinical coordinator (CC)-A stated physical therapy (PT) evaluated the safe way for R27 to transfer and move. This information was relayed	2 570			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00866	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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
2 570	Continued From page 6 to staff to implement. CC-A stated this information was to be on the care sheet so that staff were aware of how to care for R27. She was uncertain if R27's spastic rigidity was addressed in care plan, or care sheet. R27 was also on medication to help with spasms. CC-A stated most recent care conference was held on 5/15/25. CC-A stated at that time, R27 identified concerns regarding her hair not being washed, and not receiving a shower. Although this was identified on 5/15/25, and implemented on 5/20/25, the care plan and care sheet lacked indication of resident preference for bathing and desire to wash her hair. On 5/21/25 at 4:54 p.m., the director of nursing stated the care plan should be reflect resident preferences, as well as how care was to be delivered. DON stated the care plan was to be updated at the time changes implemented. DON stated this would include recommendations made by physical therapy. DON stated the care conferences were attended by CC-A. DON stated changes made to the care sheets were also to be reflected on the care plan, and should be completed at the same time. The care plan and care sheet should both accurately reflect what cares were to be performed by staff, as they direct staff as to what cares were to be performed. A request for the facility policy for care plan updates was requested but not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to revision of the care plan as needed to meet the needs of each individual resident. The director of nursing or designee could develop a system to	2 570			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00866	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
2 570	Continued From page 7 educate staff and develop a monitoring system to ensure individual care plans are revised as necessary. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570			
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess and analyze a fall with significant injury for 1 of 2 residents (R11) reviewed for falls. Findings include: R11's minimum data set (MDS) completed for significant change dated 3/5/25, was noted to be cognitively intact and able to communicate her thoughts, needs, and wishes. R11 was identified as using a walker and wheelchair for mobility.	2 830	Corrected.	7/3/25	

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00866	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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
2 830	Continued From page 8 R11 received assistance to complete her activities of daily living (ADLS), however, actively participated with cares. R11's medical diagnosis included anemia (low levels of healthy red blood cells or hemoglobin), coronary artery disease (a build up in the walls of the blood vessels which supply blood to the heart), hypertension (high blood pressure), diabetes (a group of diseases which affects how the body uses blood sugar), difficulty in walking/unsteadiness on her feet, muscle weakness, peripheral autonomic neuropathy (nerve damage which affects the system which controls involuntary body functions such blood pressure and heart rate, and weakness. The MDS identified R11 had a history of falls with no injury since the last assessment period. R11's Care Areas Assessment, dated 3/5/25, indicated areas to focus on for specialized care included activities of daily living (ADLs-including transfers and mobility), falls, pressure ulcers, pain and use of psychotropic (use of medication affect mood state and behavior) medication. R11's care plan, date of print 5/21/25, identified R11 was a fall risk related to: decreased mobility, psychotropic meds, intermittent confusion, and history of fall. Staff were directed to ensure wheelchair breaks were locked and wheelchair remained close to resident when transferring. R11 was identified as being impulsive at times. Staff were directed to remind R11 to slow down when transferring. This problem statement was identified as being initiated on 4/16/21. The care plan directed staff to monitor and document on safety, as well as review information on past falls and attempt to determine cause of falls. Staff were directed to record possible root causes, and were also directed to remove any potential	2 830			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00866	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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
2 830	Continued From page 9 causes if possible. The care plan directed staff to educate resident/family/caregivers/IDT(interdisciplinary team) as to causes. On 5/19/25 at 5:32 p.m., during interview R11 was seated in wheelchair and was propelling herself into her room. R11 stated everything was going well and reported no concerns to surveyor. On 5/21/25 at 12:49 p.m., R11 was observed walking in the hallway in gripper socks using a rolling walker. R11 was walking with occupational therapist (OT)-A who was bringing wheelchair up behind R11. R11 was observed to have abruptly stopped and sat down in wheelchair. OT-A instructed R11 of need to verbalize need/desire to sit down. OT-A did not have the wheelchair brakes on. OT was able to safely assist R11 to a seated position. During record review on 5/19/25 at 7:53 p.m., a progress note, written on 4/30/25 at 2:07 p.m., identified: Resident was sent to hospital after a fall accident with therapy. Res had a cut under left eye and hit on head. A subsequent note from 4/30/25 at 6:43 p.m., identified the head/brain/facial bones and cervical spine were assessed with computerized tomography (CT-an imaging test which helps healthcare providers detect injuries). This was completed related to R11 having experienced a fall with facial injuries. The findings included the following: Head CT: Intracranial contents: No intracranial hemorrhage (bleeding into the brain), extraaxial collection(collections of fluid within the skull, but outside the brain), or mass effect (a space occupying lesion which may increase intracranial pressure, and displace soft tissues of	2 830			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00866	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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
2 830	Continued From page 10 the brain). No CT evidence of acute infarct (tissue death). Chronic lacunar infarcts in the right basal ganglia (small deep infarcts primarily caused by chronic hypertension, atherosclerosis, and diabetes). Mild presumed chronic small vessel ischemic changes (changes related to decrease blood flow). Mild generalized volume loss. No hydrocephalus (build up of fluid in the brain). Head CT: No acute intracranial findings(no hemorrhage, shift, or mass effect). Mild generalized cerebral volume loss and presumed chronic microvascular ischemic changes of the white matter. A review of the narrative notes lacked indication of a fall analysis was completed. The initial entry did identify the fall occurred with therapy, however, it lacked further information related to the incident to attempt to determine the root cause or possible interventions to prevent this from recurring in the future. On 5/20/25 at 2:55 p.m., an interview was completed with licensed practical nurse (LPN)/clinical coordinator (CC)-A. Upon review of the electronic record, CC confirmed there were no forms on file to indicate a review of the fall had been completed. CC-A indicated the process was to have included a risk management report. The presence of a risk management report would have triggered her to have completed an Incident Review and Analysis Document. CC-A stated this should have been completed to look at the potential root cause was for the fall, and to place interventions to decrease the potential for having this occur again. On 5/22/25 at 11:57 a.m., the director of nursing (DON) stated upon review of the medical record, there were areas to document on the medication	2 830			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00866	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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
2 830	Continued From page 11 administration record (MAR) to prompt assessment of resident following the fall, however, there was no formalized fall analysis. The DON stated a risk management report should have been completed. DON stated from the risk management report, the CC would complete an Incident Review and Analysis document. This information provided details of the fall to allow for analysis of the incident to look for root cause, and identify potential interventions to be implemented to prevent future falls. DON stated this documentation should have been completed at the time of the incident. The facility policy, Fall Prevention and Management, dated 2/2024 identified the purpose of this protocol is to identify residents at risk for falls, implement fall prevention interventions, provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall. The policy identified a Fall Risk Evaluation was completed to identify and document the resident ' s risk factors for falls upon admission, annually, with a significant changed in condition, and as needed. The policy identified after the initial actions after the fall, and stabilization of the resident has been completed, nursing staff will complete an incident review and analysis. The policy identified the staff were to clarify the details of the fall, such as when the fall occurred, where it occurred and what the individual was trying to do at the time the fall occurred. The policy directed nursing staff to try to identify possible or likely causes of the incident. This would refer to resident-specific evidence including medical history, known functional impairments, etc. Staff will monitor and document the resident ' s response to and the effectiveness of interventions put in place to prevent further falls for 72 hours post fall.	2 830			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00866	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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
2 830	Continued From page 12 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventioins are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830			
2 840	MN Rule 4658.0520 Subp. 2 B Adequate and Proper Nursing Care; Clean skin Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: B. Clean skin and freedom from offensive odors. A bathing plan must be part of each resident's plan of care. A resident whose condition requires that the resident remain in bed must be given a complete bath at least every other day and more often as indicated. An incontinent resident must be checked at least every two hours, and must receive perineal care following each episode of incontinence. [144A.04 Subd. 11. Incontinent residents. Notwithstanding Minnesota Rules, part 4658.0520, an incontinent resident must be checked according to a specific time interval written in the resident's care plan. The resident's	2 840			7/3/25

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00866	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
2 840	Continued From page 13 attending physician must authorize in writing any interval longer than two hours unless the resident, if competent, or a family member or legally appointed conservator, guardian, or health care agent of a resident who is not competent, agrees in writing to waive physician involvement in determining this interval, and this waiver is documented in the resident's care plan.] Clean linens or clothing must be provided promptly each time the bed or clothing is soiled. Perineal care includes the washing and drying of the perineal area. Pads or diapers must be used to keep the bed dry and for the resident's comfort. Special attention must be given to the skin to prevent irritation. Rubber, plastic, or other types of protectors must be kept clean, be completely covered, and not come in direct contact with the resident. Soiled linen and clothing must be removed immediately from resident areas to prevent odors. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide routine bathing assistance for 1 of 1 residents (R27) reviewed for activities of daily living (ADLs). Findings include: Findings include: R27's admission Minimum Data Set (MDS) dated 5/2/25, indicated R27 was cognitively intact. The assessment identified R27 received assistance with activities of daily living (ADL's) including dressing, grooming, bathing, mobility, and incontinence care (managing of bowel and bladder). The MDS identified it was very	2 840	Corrected.		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00866	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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
2 840	Continued From page 14 important to R27 to choose between a tub bath, shower, bed bath, or sponge bath, and somewhat important to choose what clothes she wished to wear. R27's medical diagnoses included multiple sclerosis (MS), malnutrition (an imbalance of energy and nutrients consumed), thrombocytosis (increase platelet count), pseudobulbar affect (a condition characterized by uncontrollable and inappropriate episodes of laughing or crying, often disconnected from person's actual emotion state). R27 received routinely schedule pain medication, as well as availability of additional pain medication as needed. R27's care plan, with a print date of 5/21/25, identified that R27 had a self care deficit related to post surgical status, weakness and MS. The goal indicated R27 will accept assistance with self cares and will be dressed, groomed, and bathed per preferences. The care plan directed staff to follow through with instructions provided by occupational therapy (OT) and physical therapy (PT). Staff were also directed to provide with assist of one with dressing and bathing. R27's care plan also identified R27 had alteration in mobility related to post surgical status, weakness and MS. The care plan indicated R27 was to receive assist with movement in and out of bed and was to receive assist of one with transfers, however lacked further instructions. Although R27's care plan indicated R27 was on enhanced barrier precautions (increase precautions implemented to prevent the spread of infection) related to surgical incisions, the care plan lacked indication as to how the surgical sites were to be managed, additionally lacked any restrictions in showering related to incisions. The Nursing Assistant care sheet dated 5/21/25, indicated R27 was to receive assistance to	2 840			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00866	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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
2 840	Continued From page 15 transfer with an EZ stand (a mechanical lift to aid in transfers) and did not ambulate. The NA care sheet outlined R27 required assist of one with dressing, bathing, toileting, and required set up for grooming and eating. The care sheet provided no additional instructions. On 5/19/25 at 5:48 p.m., R27 and Family member (FM)-A were present in room. R27 expressed frustration she had not received a bath/shower since she had arrived. FM-A affirmed that R27 had doctor's appointments last week and wished to receive a bath/shower before going to her appointments, however, R27 was not assisted with this. R27 stated a certified nursing assistant (CNA) came in to provide assistance with a sponge bath, however, R27 wanted a shower to be able to wash her hair as it had not been washed in the weeks since admission. R27 stated the CNA "put it down that she refused" her bath. R27 reported when she asked when she could receive a shower, was told she had to wait for the next shower day. R27 stated "Nobody knows how to do a shower." R27 stated neither PT/OT had worked with her regarding the transfer into the shower chair required for completing a bath and shower. On 5/20/25, 1:01 p.m. R27 stated she was unaware she was scheduled to receive a bath this afternoon, however, stated she would like her hair washed. On 5/20/25, at 4:10 p.m. R27 was observed back in her room. R27 stated the shower was completed and hair was washed twice. R27 stated this was the first time her hair had been washed for approximately 3 weeks. During interview on 5/21/25, at 9:27 a.m. the	2 840			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00866	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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
2 840	Continued From page 16 physical therapy assistant (PTA) stated she participated in the therapy for R27. At present time, PTA stated they were working with R27 on core strength. PTA stated they were also working with R27 to be able to transfer into and out of bed, and in wheelchair. OT stated OT did not have a specific goals for showers, as they had not been informed by nursing staff of any concerns regarding showers, therefore, that had not been part of the therapy plan. During interview on 5/21/25, at 10:08 a.m. the clinical coordinator (CC)-A stated R27 had received assistance to complete bathing on 5/20/25. CC-A stated R27 was unable to complete showers/baths prior to that time related to incisions on her stomach following a laparoscopic procedure (A procedure completed with a scope through several small incisions on the abdomen). CC-A stated R27 required clearance from the medical provider because of the incisions. CC-A stated staff had offered to complete a shower on an earlier occasion, however, R27 had declined the shower related to the time of day. When asked if they had a second opportunity to receive a shower before the next scheduled bath day, CC-A stated if it was not their shower day, staff were instructed to accommodate the request if they had extra time. CC-A stated she would expect staff would have offered it multiple times until she agreed to it. CC-A stated lack of shower or washing of hair for extended time would not feel very good. CC-A stated residents were assigned a time for bathing/showering based on their room placement. When asked if resident's were allowed to choose an alternate time which worked better for them, CC-A stated they tried to work with residents, however, it was not always possible. CC-A stated she was unaware of any	2 840			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00866	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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
2 840	Continued From page 17 concerns regarding bathing status until resident care conference on 5/15/25. CC-A stated R27 had received sponge baths since her admission, however, she was unsure if her hair was washed. During interview on 5/21/25, at 4:54 p.m. the director of nursing (DON) stated baths were scheduled on a weekly basis. This was completed based on their designation based upon rooms. DON stated if the resident did not care for the slot, there might have been some flexibility in adjusting it, however, that was not always possible. DON stated "We try to be flexible but there is (was) only so much wiggle room in that." DON stated if a bath was refused, and it was requested on another day, and the aides had time, it may occur, otherwise the next bath/shower would be completed the following week on the routinely scheduled time. Upon inquiring why a shower was not completed for R27, DON stated that if the person had a lap surgery, they would not have a shower if there were restrictions placed per the doctors orders upon admission. If there were not restricted orders, the individual could receive a shower. A request was made at this time for the specific order restricting showers for R27 from the time of her admission, however, was not provided by the DON. Upon review of R27's abbreviated discharge orders from 4/28/25, there were no orders identified for wound care to laparoscopic sites, or restrictions for showering. Upon review After Discharge Orders, from 4/28/25, the notes indicated resident had a laparoscopic procedure, however, had not restricted resident from receiving showers. A review of the information in this documentation	2 840			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00866	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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
2 840	Continued From page 18 lacked indication of this restriction. A review of the standing orders, filed 5/20/25 electronically, lacked indication for shower restrictions for those with laparoscopic surgical sites. The document did refer to the policy Skin and Wound Management. The document, not labeled with R27's name, was identified as being signed by the provider 2/1/25. A review of the policy, Skin Assessment and Wound Management, dated 2/25 lacked indication as to management of a laparoscopic surgical site. A review was made of resident task documentation for bathing was completed upon receipt. During the time frame of 4/28/25 through 5/7/25, there were both daily (times four) and twice daily entries (6) where the response to bathing being entered as NA, indicating not applicable. R27's documentation from 5/8/25 through 5/23, had daily entries of NA on three days, and twice daily entries of NA on 10 occasions. The documentation reflected no entries for 5/20/25, the day R27 received assistance bathing. The documentation lacked any date where resident had been assisted with bathing since her admission of 4/28/25. A follow up interview was completed with CC-A on 5/23/25, at 1:03 p.m. CC-A stated the results NA of the task documentation indicated that staff had not provided R27 with assistance to bath during the periods of 4/28/25-5/23/25 , with the exception of assistance to bathe on 5/20/25.. On 5/23/25, at 1:05 p.m. the director of nursing stated the expectation of assigned tasks was that the staff would complete them as directed.	2 840			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00866	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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
2 840	Continued From page 19 The facility policy, titled Activities of Daily Living (ADL's) Maintain Ability Policy, dated 3/31/23, was reviewed. The statement of intent reads as follows: It is the policy of the facility to specify the responsibility to create and sustain an environment that humanizes and individualizes each resident's quality of life by ensuring all staff, across all shifts and departments, understand the principles of quality of life, and honor and support these principles for each resident; and that the care and services provided are person-centered, and honor and support each resident ' s preferences, choices, values and beliefs. Upon review of the procedure, the policy indicated: The facility will provide care and services for the following activities of daily living: a. Hygiene -bathing, dressing, grooming, and oral care... The policy also identified: A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming... SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could educate responsible staff to provide care to residents' dependant on facility staff, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of dependent resident cares to ensure their personal hygiene needs are met consistently. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 840			
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion	2 895			7/3/25

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00866	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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
2 895	Continued From page 20 Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide routine assistance with range of motion (ROM) to to improve strength, mobility and improve circulation of left arm for 1 of 1 (R29) reviewed for ROM. Findings include: R29's care plan, dated 2/14/25, indicated R29 was a fall risk related to left side(d) weakness, impaired vision. The care plan directed staff to follow PT (physical therapy) and OT (occupational therapy) instructions for mobility function. The care plan additionally identified R29 had self care deficit related to left sided weakness. The care plan directed staff R29 was to receive OT as ordered by provider. Staff were also directed to follow OT instructions. A review of the Interdisciplinary Team (IDT) Conference notes was reviewed and it was noted in the document dated, 2/13/25, R29 was	2 895	Corrected.		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00866	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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
2 895	Continued From page 21 receiving assist with from therapy for ROM with left arm. A review of the subsequent IDT notes of 3/28/25 indicated The IDT note indicated the nurse practitioner had reviewed swelling in left forearm and ordered a compression wrap for his left arm. At the care conference, family member (FM)-B inquired of use of a sling, however, this was to be used only with transfers to encourage resident to use his left arm. The IDT care conference notes of 5/2/25, identified ongoing concerns with swelling of the left forearm and use of the compression wrap was to be continued, as well as continued use of sling only with transfers. A review of the group two (2) nursing assistant care sheet, updated 5/21/25, indicated R29 had an ROM program. A review of the task list documentation from 4/23/25-5/21/25, directed staff to provide ROM to LUE (left upper extremity): all planes (the extent or limit to which a part of the body can be moved around a joint or a fixed point) one (1) direction ten (10) times each w/ (with) extended hold *signs in room on wall to help staff. Upon review of the documentation, it was noted entries for all dates, with the exception of 4/27, 4/28, and 5/17, indicated NA (not applicable-not performed). On 4/27, 4/28, and 5/17, the notation indicated the amount of repetitions as 5 (five). On 5/19/25 at 3:15 p.m., R29 was observed to be sitting in the wheelchair. His right had was noted to resting in an open position on his lap. R29 was observed to have his left arm, with left hand in an	2 895			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00866	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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
2 895	Continued From page 22 open position, rested on pillow resting on arm rest/lap. R29 stated he had received therapy, however, stated therapy had stopped. R29 stated staff were to perform exercises, gesturing to the multiple page documents posted to the wall with directions as to what to do, however, stated "no one does this." On 5/22/25 at 12:14 p.m., R29 was observed to have a visitor at that time, who was observed as she provided assistance to R29 with range of motion for R29. The resident visitor (RV)-1, who identified herself as a friend, stated she assisted R29 with his exercises when she was here, and indicated she followed the directions on the wall. The visitor indicated they liked to come and make R29's day better. On 5/22/25, at 12:24 p.m., certified nursing assistant (CNA)-D stated cares performed for residents were documented on the tasks listing. CNA-D looked at this and identified R29 was to receive ROM to the left upper extremity, as indicated on the tasks section of the medical record. CNA-D stated that she had not performed this yet today, but planned to perform. On 5/22/25, at 2:35 p.m. and interview was held with CNA-B and CNA-C. CNA-B stated it was rare to complete ROM in general. CNA's B and C both stated the most important tasks were completed, which included feeding assists and showers, however, ROM was infrequently done for the residents assigned. On 5/23/25 at 1:03 p.m., licensed practical nurse (LPN)/clinical coordinator (CC)-A indicated upon review of the task listing for R29, completion of ROM was lacking for all days with the exceptions of 4/27, 4/28, and 5/17. CC-A stated the	2 895			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00866	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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
2 895	Continued From page 23 documentation indicated staff were not completing ROM. CC-A stated it was her expectation that staff should have been completing ROM. CC-A verified the care sheet directed staff to perform the ROM program. CC-A stated she was unaware the ROM was not consistently completed. On 5/23/25, at 1:05 p.m. the director of nursing stated she had reviewed the information as documented on the tasks sheet and identified it had not been done often. DON stated it was her expectation that ROM was completed as directed, on a daily basis as outlined. A facility policy, Activities of Daily Living (ADLs)/Maintain Abilities Policy, dated 3/31/23, identified the intent as being: It is the policy of the facility to specify the responsibility to create and sustain an environment that humanizes and individualizes each resident ' s quality of life by ensuring all staff, across all shifts and departments, understand the principles of quality of life, and honor and support these principles for each resident; and that the care and services provided are person-centered, and honor and support each resident ' s preferences, choices, values and beliefs. Within the policy, it was identified under the procedure the following: 1. Based on the comprehensive assessment of a resident and consistent with the resident ' s needs and choices, the facility will provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. 2. The facility will ensure a resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living. The facility policy	2 895			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00866	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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
2 895	Continued From page 24 lacked specific identification as to process/policy for performance of ROM, however, when asked for a more specific policy, the facility stated ROM was addressed within the ADL's policy. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for limited range of motion/ambulation to assure they are receiving the necessary treatment/services to prevent further limitation in range of motion. The director of nursing or designee, could conduct random audits of the delivery of care to ensure appropriate care and services are implemented. The results of the audits could be brought to the quality assurance committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895			
2 995	MN Rule 4658.0610 Subp. 3 Dietary Staff Requirements -Grooming. Subp. 3. Grooming. Dietary staff must wear clean outer garments. Hairnets or other hair restraints must be worn to prevent the contamination of food, utensils, and equipment. Hair spray is not an acceptable hair restraint. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility staff failed to consistently wear hairnets in the kitchen while preparing food. This had the potential to affect all 32 residents who received food from the kitchen.	2 995	Corrected.		7/3/25

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00866	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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
2 995	Continued From page 25 Findings include: On 5/19/25 at 12:18 p.m., CD was observed to wearing a hair net; however, the sides of her hair were not completely contained within the hair net. CD was observed with hair net not partially covering her hair in the kitchen, and in the serving kitchen. On 5/20/25 at 12:26 p.m., RCD was observed in the serving kitchen. Although RCD was observed to have a hair net in place, it lacked coverage of her bangs, which were noted to be uncovered on her forehead. On 5/20/25 at 3:43 p.m., registered dietitian (RD) stated hair nets were to be worn in the kitchen, and outside of the kitchen when serving food. RD stated hair nets were to be worn so it covered all of the person's hair. Hair was to be tucked in, no matter what part of your hair it was. On 5/20/25 at 3:47 p.m., RDC acknowledged her bangs were not covered up by her hairnet and stated "I know better." On 5/20/25 at 5:13 p.m., dietary assistant (DA)-B, was observed placing tablecloths on serving tables in the dining room. DA-B's hair was observed to be braided and pulled back away from her face, however, there were areas around forehead and ears where the hair net was not restraining/containing the hair. Upon interview, DA-B stated she was unaware her hair was outside of the hair net, and stated it was important for hair nets to be used so that the hair would not get into the food. On 5/21/25 at 4:45 p.m., DA-C was observed in the dining room setting up tables for the evening	2 995			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00866	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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
2 995	Continued From page 26 meal. DA-C was observed to have a hair net in place to cover his head, however, DA-C was also observed to have facial hair present with a light mustache and beard. DA-C was not wearing any facial hair restraint at this time. On 5/21/25 at 4:55 p.m., RDC was observed walking by at the time DA-C was preparing the dining room. Surveyor inquired of RDC if DA-C typically used a facial hair restraint? RDC stated, "He typically does, for sure." 5/21/25 at 4:59 p.m., RDC approached surveyor and stated she had followed up on use of beard nets at the facility. RDC stated the facility lacked beard nets in house. RDC stated in the interim, DA-C would cover face with a face mask. A facility policy, Food Preparation and Service, revised April of 2019, identified under Food Service/Distribution that "Food and nutrition services staff (were to) wear hair restraints (hair net, hat, beard, restraint, et.) so hair does not contact food. SUGGESTED METHOD OF CORRECTION: The administrator, registered dietician, or designee could ensure dietary staff are educated in expectation of hair net use, then could audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 995			
21025	MN Rule 4658.0615 Food Temperatures Potentially hazardous food must be maintained at 40 degrees Fahrenheit (four degrees centigrade) or below, or 150 degrees Fahrenheit (66 degrees	21025			7/3/25

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00866	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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
21025	Continued From page 27 centigrade) or above. "Potentially hazardous food" means any food subject to continuous time and temperature controls in order to prevent the rapid and progressive growth of infectious or toxigenic microorganisms. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to monitor food temperatures to ensure safety which had the potential to affect all 32 residents who received food from the kitchen. Findings include: On 5/19/25 at 12:14 p.m., temperature logs were received from 5/16/25 to the present time on 5/19/25 at 12:14 p.m. The culinary services cook (CSC)-A stated she had temped the foods earlier yet had not recorded them. The temperature log reflected no temperatures had been entered for 5/16/24-5/19/25. Additional logs were requested from the CD from the start of the month. Upon review of the temperature logs, it was noted from 5/1/25 -5/15/25, there were 11 meals out of 45 where temperatures were not recorded. CD stated the temperatures were to be checked prior to serving the meals, and indicated the temperatures were to be logged immediately after they are checked. On 5/20/25 at 3:32 p.m., RCD stated staff were to check the temperature of foods right before the meal was served. RCD stated there were interventions to maintain food temperatures which included heating pellets, heating plates, domed plates. If the food was not maintaining the desired temperature, her concern would be related to the delivery process, function of the steam table	21025	Corrected.		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00866	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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
21025	Continued From page 28 being on, and equipment being efficiently used. A facility policy titled Food Preparation and Service, revised April of 2019, identified under Food Preparation, Cooking and Holding Time/Temperatures that food thermometers used to check food temperatures were clean, sanitized, and calibrated for accuracy. The policy identified under Food Service and Distribution, that the proper hot and cold temperatures were maintained during food service. The policy indicated the temperature of foods held in steam tables were monitored throughout the meal by food and nutrition services staff. The policy lacked definition as to when the temperatures were to be initially taken prior to meals, and the parameters when the temperatures are to be rechecked. SUGGESTED METHOD OF CORRECTION: The dietary manager, registered dietician, or administrator, could review/revise policies related to food temperatures, educate staff and audit to maintain compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21025			
21100	MN Rule 4658.0650 Subp. 5 Food Supplies; Storage of Perishable food Subp. 5. Storage of perishable food. All perishable food must be stored off the floor on washable, corrosion-resistant shelving under sanitary conditions, and at temperatures which will protect against spoilage. This MN Requirement is not met as evidenced by:	21100			7/3/25

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00866	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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
21100	Continued From page 29 Based on observation, interview and document review, the facility failed to consistently date fresh and frozen items at the time they were opened, or placed in a container, and failed to remove items which were beyond the acceptable date of use from the refrigerator. This had the potential to affect all 32 current residents, as well as staff and visitors who ate the food from the kitchen. Findings include: On 5/19/25 at 11:31 a.m., the culinary director (CD) reviewed the products of the refrigerator at this time. The CD stated food items should be used within seven days of placing in the refrigerator. The following items were noted to be in the refrigerator and outside of the stated parameters: A five-pound box of bacon, with half of the box remaining was observed to be in an opened paper box which was not sealed. This was removed by the CD. A bottle of lemon juice which was noted to be 32 ounces, with half of a bottle remaining. The manufacturer expiration date was noted to be 3/25. The bottle had been dated on 3/24 as being opened. A stack of sliced cheese, approximately one and a half inches in height, was wrapped in plastic wrap, and was dated 5/8/25. The wrapping was not secured, and one corner of the cheese was opened with cheese crumbling off. The package of cheese was free from mold. The CD removed the cheese from the refrigerator to be repackaged. A one pound package of butter, was observed to be partially unwrapped, and noted to have approximately half of the block remaining. This was undated. This removed from the refrigerator and disposed of.	21100	Corrected.		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00866	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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
21100	Continued From page 30 A six quart container was observed to be in the refrigerator with two quarts of black olives remaining. This was noted to be dated 5/1/25. This was removed from the refrigerator and disposed of. An open package of ham, containing six slices of ham was observed to be dated 5/6/25. This was removed from the refrigerator and disposed of. A one-pound package of bologna, white in color, with watery substance observed at the bottom of the packaging was noted to be dated 3/31/25. This was disposed of. A bag of precooked sausage, dated 5/8/25, was observed to be in the refrigerator. CD stated they had just placed this in the refrigerator on Friday, 5/16/25, however, acknowledged staff would be unaware of the date of 5/8/25 being the date received on delivery and not the date the bag was placed in the refrigerator. CD stated precooked foods could be stored seven days. A sandwich size baggy of chopped up onions was observed in the refrigerator, dated 5/7/25. There was a watery substance at the bottom of the bag, and the onions were soft to touch. This bag was removed and disposed of. On the upper shelf of the refrigerator, there was an undated plastic cup, approximately two ounces in size, of sour cream. This item was removed and disposed of. The dry storage room was surveyed and it was noted to have two onions which had two inches of green sprouts out of the top of them. The onions were noted by the CD to be soft and spoiled and were disposed of. A review of the food items in the freezer was completed and the following was identified. Within the freezer, there was noted to be two	21100			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00866	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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
21100	Continued From page 31 chunks of ham in a plastic bag, dated 5/14/25, which CD noted to weigh approximately one and a half pounds which had a large amount of ice crystals surrounding the chunk of ham and laying in the bottom of the bag. A second bag of ham was also noted to be in a plastic bag, covered with many crystals, both on the ham and in the bottom of the bag. This bag was measured at three pounds. CD stated she was unsure if the ham was not cooled down properly to cause formation of ice crystals. Both bags of ham were removed and disposed of. A four-pound bag of fully ice encrusted fajita blend vegetables was observed. This contained a pepper and onion mix. This was not opened and undated. This was removed and disposed of. A review of other frozen vegetables was completed with no other vegetables noted to be encased with ice. A bag of chili sauce was found thawed in freezer, with a date of being opened as 5/13/25, however, was not frozen. The bag was noted to weigh was almost three pounds. CD was unsure why this would have been dated 5/13/25, and yet be thawed to touch. On 5/20/25 at 3:20 p.m.,Regional Culinary Director (RCD) stated foods are dated upon arrival/receipt. RCD stated food products should then be dated with date opened. RCD stated if the food product was a cooked product, it was to be used within three days. RCD stated if it was cheese, it was to be discarded after seven days. Ham was to be disposed of within seven days. A facility policy, Food Receiving and Storage, revised October 2017, identified foods were to be received and stored in a manner that complied with safe food handling practices. The policy indicated all foods stored in the refrigerator or	21100			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00866	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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
21100	Continued From page 32 freezer were to be covered, labeled, and dated ("use by" date). Although the policy identified to products were to be dated, it lacked definition as to what the time frames were for the food products to be used by, with the exception being that beverages must be dated when opened and discarded after twenty four hours. A policy titled Refrigerators and Freezers, undated, indicated the facility will ensure safe refrigerator and freezer maintenance, temperature and sanitation, and will observe food expiration guidelines. The policy stated all food shall be appropriately dated to ensure proper rotation by expiration dates. "Received" dates (dates of deliver) will be marked on cases and on individual items removed from cases for storage. "Use by" dates will be completed with expiration dates on all prepared foods in the refrigerators. Expiration dates on unopened food will be observed and "use by" dates indicated once food is opened. All expired items were to be discarded. Although the policy addresses the "use by" date, the policy lacks specifications to what the parameters are to be used for determining the "use by date". SUGGESTED METHOD OF CORRECTION: The administrator, registered dietician, or designee could ensure foods are stored and labeled properly to prevent potential degraded food served to residents of the facility. The facility could update or create policies and procedures, and educate staff on specific requirements or interventions related to food storage and labeling. The administrator, registered dietician, or designee could perform audits for a designated amount of time as determined by the Quality Assurance Performance Improvement (QAPI)	21100			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00866	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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
21100	Continued From page 33 committee to ensure food items are stored and labeled appropriately. The facility could report those findings to QAPI for further recommendations and determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21100	Corrected.		7/3/25
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications had both open dates and expiration dates marked on the medications so staff new how long the medications were good for. This had the ability to affect all residents on the transitional care unit (TCU) who received medications. Findings include: On 5/21/25 at 12:21 p.m., a review of the TCU medication care and treatment cart was performed. Three different insulin dial up pens were observed without open dates or expiration dates documented on the pens. Three different inhalers were also observed without open dates or expiration dates. During an interview on 5/21/25 at 12:36 p.m., licensed practical nurse (LPN)-A reviewed the medications and confirmed there were no open dates or expiration dates on the medications.	21620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00866	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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
21620	Continued From page 34 LPN-A could not report when the medications were opened or how long they were good for once the medications were opened. LPN-A did not know how long insulins or inhalers were good for after opened and stated, "I need to check with my supervisor." On 5/22/25 attempts to contact the pharmacy consultant were not successful. During an interview on 5/22/25 at 12:27 p.m., the director of nursing (DON) stated an expectation that medication would be dated with both the open date and expiration date, so staff were aware how long they were good to administer. Administering medication beyond the expiration date could result in the resident responding differently to the medication as the potency may change. A facility policy on dating and disposal of multi-use medication was requested, however, none was provided F761 SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist should review, revise, or create policies and procedures for proper labeling and storage of medications and or/ storage of items in the medication room or refrigerators. Nursing and/or medication aide staff should be educated to those changes. The DON or designee, and pharmacist, should routinely audit all medications and storage to ensure compliance. The results of those audits should be taken to QAPI ongoing to determine compliance. TIME PERIOD FOR CORRECTION: Twenty one	21620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00866	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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
21620	Continued From page 35 (21) days.	21620			
21825	MN St. Statute 144.651 Subd. 9 Patients & Residents of HC Fac.Bill of Rights Subd. 9. Information about treatment. Residents shall be given by their physicians complete and current information concerning their diagnosis, treatment, alternatives, risks, and prognosis as required by the physician's legal duty to disclose. This information shall be in terms and language the residents can reasonably be expected to understand. Residents may be accompanied by a family member or other chosen representative, or both. This information shall include the likely medical or major psychological results of the treatment and its alternatives. In cases where it is medically inadvisable, as documented by the attending physician in a resident's medical record, the information shall be given to the resident's guardian or other person designated by the resident as a representative. Individuals have the right to refuse this information. Every resident suffering from any form of breast cancer shall be fully informed, prior to or at the time of admission and during her stay, of all alternative effective methods of treatment of which the treating physician is knowledgeable, including surgical, radiological, or chemotherapeutic treatments or combinations of treatments and the risks associated with each of those methods. This MN Requirement is not met as evidenced	21825			7/3/25

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00866	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
21825	Continued From page 36 by: Based on observation, interview and record review, the facility failed to obtain proper consent for use of psychotropic medications (a drug which affects behavior, mood, thoughts or perception) for 1 of 5 residents (R35) reviewed for unnecessary medications. Findings include: R35's admission Minimum Data Set (MDS) dated 3/25/25, indicated R35 had impaired cognition. R35 was noted to receive assist with activities of daily living (ADLs) including dressing, grooming, bathing, and mobility. R35's medical diagnoses included unspecified encephalopathy (brain disease, damage, or malfunction which encompasses a range of conditions that could cause brain dysfunction, which might manifest as confusion, memory loss, personality changes, or severe symptoms like coma), cancer, atrial fibrillation (an abnormal heart rhythm which has been known to lead to complications including stroke, blood clots, and heart failure), hypertension (high blood pressure), arthritis (inflammation of joints), dementia, anxiety, depression, visual hallucinations (seeing something that is not there), adjustment disorder with anxiety, chronic pain syndrome, and fibromyalgia (symptoms of widespread chronic pain, headaches, depression and other symptoms). R35's care plan printed 5/22/25, indicated R35 had "alteration in cognition related to confusion, disorientation to place and time. Poor insight to her deficits or cognitive loss. Poor historian. Sundowning type behaviors of crying and calling out. Has decreased in intensity since admission." The problem statement identified R35 had the	21825	Corrected.		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00866	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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
21825	Continued From page 37 diagnosis of major neurocognitive disorder, with behavioral disturbance, encephalopathy due to medical illness (various infections), visual hallucinations, and low vision due to retinal pigmentation disease. The care plan directed staff to follow recommendations from mental health provider. The care plan lacked indication of medications used to aide with mood state and behavior. R35's Medication Administration Record (MAR), printed 5/20/25, indicated R35 received the following medications: - lorazepam 0.5 milligrams (mg) by mouth one time a day for agitation. Start date of 4/3/25. (benzodiazepines used for anxiety). - lorazepam 0.5 mg by mouth every four hours as needed for anxiety or agitation for six months. Start date 4/3/2025. - risperidone 1 mg by mouth at bedtime for agitation/delirium. Start date of 5/5/25. (antipsychotic- works by changing certain signals in your brain which affect how you feel and act). - risperidone 0.5 mg by mouth two times a day for delirium/ agitation. Start date 5/5/25. R35 was noted to receive Lorazepam on 13 occasions in April, with results marked as effective on 10 of the 13 occasions used. This was noted to be used on two occasions in May (5/9/25, 5/13/25) with effective results on each occasion. The May MAR was reviewed for the dates of 5/1/25-5/20/25. A review of R35's medical record lacked indication informed consent had been received from R35's responsible party upon admission to the facility, as well as with change of medication dosing/frequency.	21825			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00866	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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
21825	Continued From page 38 On 5/20/25 at 3:52 p.m., R35 was observed in her room, resting on her bed, with blanket in place. R35 had a visitor in her room, playing her guitar, and singing to resident. Resident was observed to be awake and was interacting with her visitor. During interview on 5/22/25 at 1:46 p.m., the director of nursing (DON) stated completion of an informed consent was typically completed within the first week following admission if a resident was admitted on a psychotropic medication. DON stated this was typically completed by the floor nurse, however, if it had not been completed within that time frame, it was followed up on by either the licensed practical nurse, clinical coordinator (CC) or the DON. DON stated consents were to be obtained when new medications were added, as well as updated when changes were made in dosage and frequency of existing meds. A request was made for the documentation of informed consent for both risperidone and lorazepam, which were unable to be located in the medical record. DON stated she also did not find them uploaded on the record. DON stated it was important to receive informed consent for psychotropic medications, as they are medications which have the potential to have more adverse (negative) side effects than other medications, and it is important to notify the responsible part of the possible side effects. The facility policy, titled Psychotropic Medication Use Policy, created 4/25, identified the facility would a. Obtain informed consent from the resident and/or resident representative and document education, information regarding the medication indication and directions for use, side effects and	21825			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00866	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
21825	Continued From page 39 potential adverse consequences, risks and benefits of the medication and resident choice. b. Discuss any advance directives that the resident has formulated to provide care consistent with resident choice. c. The resident and/or responsible party will be notified regarding dose changes. d. This will be documented in the progress notes. e. Consents and any psychotropic medications will be reviewed quarterly at resident care conferences. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee review and revise policies related to informed consent, educate staff and conduct audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21825			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

Travis Z. Ahrens 49207

PRINTED: 05/28/2025

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245298		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/20/2025	
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT TWIN RIVERS LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 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
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/20/2025. At the time of this survey, The Estates at Twin Rivers was found 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 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 32 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is met.			K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 21, 2026

Administrator
The Estates At Twin Rivers LLC
305 FREMONT STREET
ANOKA, MN 55303

RE: CCN: 245298
Cycle Start Date: May 23, 2025

Dear Administrator:

On July 17, 2025, the Minnesota Department of Health 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 blue 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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 21, 2026

Administrator

The Estates At Twin Rivers LLC

305 FREMONT STREET

ANOKA, MN 55303

Re: Reinspection Results

Event ID: M6TJ12

Dear Administrator:

On July 17, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 23, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any 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

