DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
May 21, 2025

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

RE: CCN: 245298
Cycle Start Date: May 1, 2025

Dear Administrator:

On May 19, 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,

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 21, 2025

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

Re: Reinspection Results
Event ID: 440Q12

Dear Administrator:

On May 19, 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 1, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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
May 13, 2025

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

RE: CCN: 245298
Cycle Start Date: May 1, 2025

Dear Administrator:

On May 1, 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), 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:

Terri Ament, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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 1, 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 1, 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.

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245298	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 5/1/25, a standard abbreviated survey was conducted at your facility. 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: H52983389C (MN00112488) and H52983736C (MN00112636) with a deficiency issued at F656 and F689. 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 that substantial compliance with the regulations has been attained.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -	F 656		5/16/25

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

Electronically Signed | 05/19/2025

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.

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F 656	Continued From page 1 (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide an individualized care plan for 1 of 3 residents (R1) reviewed for smoking plans.	F 656	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	

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F 656	Continued From page 2 Findings include: R1's quarterly Minimum Data Set (MDS) dated 3/4/25 indicated R1 had a diagnosis of cerebral infarction (stroke). The MDS indicated R1 required assistance with personal care, transfers, and mobility. R1's care plan dated 4/30/25 directed R1 had a history of smoking at the facility, and was noncompliant with the smoking policy. R1's care plan indicated he had been noted to be smoking in his room, and he was educated on the safety risk to himself and others. The care plan listed interventions of resident can smoke outside with family, and was deemed unsafe to store/handle his own smoking materials. The goal listed on R1's care plan was he would not smoke while at the facility. The undated facility care sheet (nursing assistant and nurse care guide) lacked a smoking plan or plan for supervision for R1. R1's Smoking Assessment dated 4/16/25 indicated R1 was caught smoking in his room, and per the administrator was not allowed to smoke while at the facility. R1's chart lacked a Smoking Assessment after 4/16/25. On 4/28/25, a progress note indicated social worker (SW)-A reviewed the facility smoking policy with R1, concerns of borrowing cigarettes from other residents, and staffing limitations on frequent supervised smoking. On 5/1/25, at 8:52 a.m. R1 stated he was aware smoking was prohibited inside the facility. He	F 656	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. F656: Develop/Implement Comprehensive Care Plan Immediate corrective action: Facility immediately redid resident (R1) smoking assessment and updated his care plan to reflect that resident was able to smoke with supervision while at the facility. Residents care sheet was also updated to reflect that resident needed supervision while smoking in the designated smoking area at the facility. Corrective action as it applies to others: A full-house audit was conducted to identify	

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F 656	Continued From page 3 smoked in his room on 4/25/25 and 4/26/25, but denied prior incidents of smoking inside the facility. He did not have smoking materials in his possession. On 5/1/25, at 9:30 a.m. SW-A stated staff were performing safety checks every 15 minutes to assess for smoking immediately following the smoking incident on 4/26/25. On 5/1/25 at 10:02 a.m. nursing assistant (NA)-A stated R1 was not allowed to smoke at the facility unless he had family with him to take him outside. Staff were made aware of care plans via the care sheets provided. NA-A verified the care sheets lacked any information on R1's smoking plan, smoking restrictions, and safety checks. On 5/1/25 at 11:14 a.m. nurse practitioner (NP)-A stated R1 was not safe to smoke by himself. The current plan was for family to assist and supervise him with smoking. R1 should have his smoking materials kept at the nursing station. On 5/1/25 at 12:51 p.m. agency staff licensed practical nurse (LPN)-A stated she was not aware of R1's recent unsafe smoking practices or restricted smoking privileges. The care sheet lacked direction regarding R1's smoking plan, and she was not provided verbal direction from the previous nurse on duty. On 5/1/25 at 1:13 p.m. the administrator stated staff knew to "keep an eye on him by word of mouth." She expected this to be shared in nurse-to-nurse reporting. R1's smoking privileges had been suspended, and would be re-evaluated in two weeks.	F 656	all residents who smoke. Smoking assessments were reviewed to ensure accuracy and care plans were updated as needed. If a resident had stopped smoking or was newly admitted, a new assessment was completed, and care plans were adjusted accordingly to reflect current smoking status. Staff received education on R1s updated smoking care guidelines and the facility smoking policy and how to proceed if any other resident attempts to utilize smoking materials inside the facility. Recurrence will be prevented by: Director of Nursing Services or Designee will complete audits of (3) residents that identify as smokers weekly for four (4) weeks and monthly thereafter for two (2) months. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence. Corrective action will be completed on or before 5/16/2025	

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F 656	Continued From page 4 On 5/1/25 at 1:16 p.m. the director of nursing (DON) stated the smoking plan was not included on the care sheets. She expected the nurses to share this in their nurse-to-nurse reports. The facility policy Care Planning dated 11/24 directed the care plan shall be used in developing the resident's daily care routines, and will be used by staff personnel for the purposes of providing care or services to the resident. The plan of care will be utilized to provide care to the resident. The care plan is to be modified and updated as the condition and care needs of the resident changes.	F 656		
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 provide adequate supervision for 1 of 3 residents (R1) reviewed for safe smoking, after R1 was discovered smoking in his room on multiple occasions. Findings include: R1's quarterly Minimum Data Set (MDS) dated 3/4/25 indicated R1 had a diagnosis of cerebral infarction (stroke). The MDS indicated he	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	5/16/25

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F 689	Continued From page 5 required assistance with personal care, transfers, and mobility. R1's care plan dated 4/30/25 directed R1 had a history of smoking at the facility, and was noncompliant with the smoking policy. R1's care plan indicated he had been noted to be smoking in his room, and he was educated on the safety risk to himself and others. The care plan listed interventions of resident can smoke outside with family, and was deemed unsafe to store/handle his own smoking materials. The goal listed on R1's care plan was he would not smoke while at the facility. The undated facility care sheet (nursing assistant and nurse pocket care guide) lacked a smoking plan or plan for supervision for R1. R1's smoking assessment dated 4/16/25 indicated R1 was caught smoking in his room, and per the administrator was not allowed to smoke while at the facility. R1's chart lacked a smoking assessment after 4/16/25. On 4/16/25 at 5:36 p.m., a progress note indicated on 4/15/25 at 4:21 p.m. the administrator received a call informing her R1 was smoking in his room. Administrator noticed ashes on tray table and a cigarette which had been lit and burnt out. On 4/25/25 at 5:56 p.m. a progress note indicated R1 was smoking in his room at 5:40 p.m. On 4/26/25 at 12:40 a.m. a progress note indicated the odor of cigarette smoke was coming from R1's room. A nurse observed R1 sitting in his wheelchair, throwing cigarette ashes into a	F 689	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. F689: Free of Accident Hazards/Supervision/Devices Immediate corrective action: The facility immediately purchased a lockbox for R1 to allow the resident to continue keeping smoking materials in their room safely. The nurse holds the key for the lock box on the nursing cart and unlocks for the resident to smoke during scheduled, supervised, smoking times. R1s care plan was updated, the care sheet was updated to reflect that resident had a lock box in his room, and a new smoking assessment was completed. Resident signed education provided by the director of nursing as to utilize the lock box and assistance from staff when wanting to utilize smoking materials. Corrective action as it applies to others: No like residents were identified as facility	

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F 689	Continued From page 6 cup of milk. Staff removed the cigarette and left the room. When the nurse re-entered the room, R1 was observed smoking another cigarette, with ashes all over the floor. On 4/26/25 at 1:31 a.m. a progress note indicated R1 was smoking a cigarette (in his room). On 5/1/25 at 9:30 a.m. SW-A stated R1 was discovered smoking in his room by a staff member on 4/25/25 and again on 4/26/25. R1 had refused to relinquish his smoking materials. The smoking policy was reviewed with R1 on 12/12/24, 4/16/25 and 4/28/25. R1 was only allowed to smoke if he was supervised by family. Staff were performing safety checks every 15 minutes to assess for smoking immediately following the smoking incident on 4/26/25. On 5/1/25 at 9:30 a.m. SW-A stated R1 was discovered smoking in his room by a staff member on 4/25/25 and again on 4/26/25. R1 had refused to relinquish his smoking materials. The smoking policy was reviewed with R1 on 12/12/24, 4/16/25 and 4/28/25. R1 was only allowed to smoke if he was supervised by family. Staff were performing safety checks every 15 minutes to assess for smoking immediately following the smoking incident on 4/26/25. On 5/1/25 at 10:02 a.m. nursing assistant (NA)-A stated R1 was not allowed to smoke at the facility unless he had family with him to take him outside. Staff were made aware of care plans via the care sheets provided. NA-A verified the care sheets lacked any information on R1's smoking plan, smoking restrictions, and safety checks. On 5/1/25 at 11:14 a.m. nurse practitioner (NP)-A	F 689	has not had any other residents attempt to utilize smoking materials or devices inside the building. Staff received education on R1s updated smoking care guidelines and the facility smoking policy and how to proceed if any other resident attempts to utilize smoking materials inside the facility. Recurrence will be prevented by: Director of Nursing Services or Designee will complete audits of (3) smokers and/or new admissions that smoke weekly for four (4) weeks and monthly thereafter for two (2) months. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence. Corrective action will be completed on or before 5/16/2025	

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F 689	Continued From page 7	F 689		

stated R1 was not safe to smoke by himself. The current plan was for family to assist and supervise him with smoking. R1 should have his smoking materials kept at the nursing station.

On 5/1/25 at 12:51 p.m. agency staff licensed practical nurse (LPN)-A stated she was not aware of R1's recent unsafe smoking practices or restricted smoking privileges. The care sheet lacked direction regarding R1's smoking plan, and she was not provided verbal direction from the previous nurse on duty.

On 5/1/25 at 1:13 p.m. the administrator stated R1 was caught smoking in his room on the evening of 4/25/25. R1 had been away from the facility for a short time that evening. When he returned to the facility later that night, he "lit up a cigarette three more times." This was the second time in the past two weeks R1 was caught smoking in his room. NA-A took R1 outside on 5/1/25 because he wanted to "get some fresh air." Once they came back inside, NA-A reported R1 smoked a cigarette while outside, as he had possession of smoking materials. The staff knew to "keep an eye on him by word of mouth." She expected this to be shared in nurse-to-nurse reporting. R1's smoking privileges had been suspended, and would be re-evaluated in two weeks.

On 5/1/25 at 2:04 p.m. NA-B stated R1 told her he was going to smoke in his room if he couldn't smoke outside on 4/25/25. R1 had smoked almost a full cigarette when she discovered him smoking in his room.

On 5/1/25 at 2:24 p.m. NA-A stated he brought R1 outside around 12:00 p.m., as R1 stated he

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	245298	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 8 wanted to get fresh air. While outside, R1 took a cigarette and lighter out of his picket and proceeded to smoke. Once they were back inside the building, he informed the administrator immediately. The facility policy Resident Smoking dated 10/24, directed all smoking devices, including electronic devices, will be lit/used in designated smoking areas only. Residents who choose to smoke will be evaluated upon admission, quarterly, annually and if significant change in condition/cognition exists or resident exhibits inability to follow safe smoking practices. Residents requiring supervision will receive assistance with smoking, in accordance with facility and resident specific practices as identified on the individual resident care plans.	F 689		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 13, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: 440Q11

Dear Administrator:

The above facility was surveyed on May 1, 2025 through May 1, 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:

Terri Ament, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00866	A. BUILDING: _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/1/25, a complaint 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 licensing order(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaint was reviewed with no deficiency issued: H52983389C (MN00112488) AND The following complaint was reviewed: H52983736C (MN00112636) with a licensing order issued at (4658.0405, Subpart 3) Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at 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	2 000		

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2 000	Continued From page 2 be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide an individualized care plan for 1 of 3 residents (R1) reviewed for smoking plans. Findings include: R1's quarterly Minimum Data Set (MDS) dated 3/4/25 indicated R1 had a diagnosis of cerebral infarction (stroke). The MDS indicated R1 required assistance with personal care, transfers, and mobility. R1's care plan dated 4/30/25 directed R1 had a history of smoking at the facility, and was	2 565	Corrected.	5/16/25

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2 565	Continued From page 3 noncompliant with the smoking policy. R1's care plan indicated he had been noted to be smoking in his room, and he was educated on the safety risk to himself and others. The care plan listed interventions of resident can smoke outside with family, and was deemed unsafe to store/handle his own smoking materials. The goal listed on R1's care plan was he would not smoke while at the facility. The undated facility care sheet (nursing assistant and nurse care guide) lacked a smoking plan or plan for supervision for R1. R1's Smoking Assessment dated 4/16/25 indicated R1 was caught smoking in his room, and per the administrator was not allowed to smoke while at the facility. R1's chart lacked a Smoking Assessment after 4/16/25. On 4/28/25, a progress note indicated social worker (SW)-A reviewed the facility smoking policy with R1, concerns of borrowing cigarettes from other residents, and staffing limitations on frequent supervised smoking. On 5/1/25, at 8:52 a.m. R1 stated he was aware smoking was prohibited inside the facility. He smoked in his room on 4/25/25 and 4/26/25, but denied prior incidents of smoking inside the facility. He did not have smoking materials in his possession. On 5/1/25, at 9:30 a.m. SW-A stated staff were performing safety checks every 15 minutes to assess for smoking immediately following the smoking incident on 4/26/25. On 5/1/25 at 10:02 a.m. nursing assistant (NA)-A stated R1 was not allowed to smoke at the facility	2 565		

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2 565	Continued From page 4 unless he had family with him to take him outside. Staff were made aware of care plans via the care sheets provided. NA-A verified the care sheets lacked any information on R1's smoking plan, smoking restrictions, and safety checks. On 5/1/25 at 11:14 a.m. nurse practitioner (NP)-A stated R1 was not safe to smoke by himself. The current plan was for family to assist and supervise him with smoking. R1 should have his smoking materials kept at the nursing station. On 5/1/25 at 12:51 p.m. agency staff licensed practical nurse (LPN)-A stated she was not aware of R1's recent unsafe smoking practices or restricted smoking privileges. The care sheet lacked direction regarding R1's smoking plan, and she was not provided verbal direction from the previous nurse on duty. On 5/1/25 at 1:13 p.m. the administrator stated staff knew to "keep an eye on him by word of mouth." She expected this to be shared in nurse-to-nurse reporting. R1's smoking privileges had been suspended, and would be re-evaluated in two weeks. On 5/1/25 at 1:16 p.m. the director of nursing (DON) stated the smoking plan was not included on the care sheets. She expected the nurses to share this in their nurse-to-nurse reports. The facility policy Care Planning dated 11/24 directed the care plan shall be used in developing the resident's daily care routines, and will be used by staff personnel for the purposes of providing care or services to the resident. The plan of care will be utilized to provide care to the resident. The care plan is to be modified and updated as the condition and care needs of the resident	2 565		

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2 565	Continued From page 5 changes. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could audit the care plans for residents who smoke, to provide clear direction regarding their smoking plan and and smoking materials. The DON or designee could audit the care plans and communication tools to inform staff on smoking plans for residents who smoke. The DON or designee could review and revise the policy, and educate staff on the policy. The Quality Assessment Performance Improvement (QAPI) committee could review the audits to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		