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	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Twin Rivers LLC	305 Fremont Street Anoka, MN 55303

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48040 Based on interview and document review, the facility failed to provide timely notification for change in condition to the physician for 1 of 3 residents (R3) reviewed for quality of care. Findings include: R3's Admission Record dated 12/28/24 indicated R3's diagnoses included and type two diabetes mellitus. R3's annual Minimum Data Set (MDS) dated [DATE] indicated R3 had moderate cognitive impairment. R3's care plan dated 1/2/25, indicated R3 had type two diabetes mellitus, with staff interventions to monitor blood sugars, and keep the provider informed per resident orders. R3's Provider Order dated 12/28/24 indicated blood glucose checks before meals and bedtime. Call the provider if blood sugars less than 75 or greater than 400. R3's orders dated 12/28/24 included insulin Aspart subcutaneous solution pen-injector 100 unit/milliliter (ml). Inject 20 units subcutaneously with meals and 10 units as needed for diabetes mellitus. May take additional 10 units for higher carb meal daily, up to 70 units total in 24 hours. On 1/4/25 at 3:44 p.m. vital signs indicated R3's blood sugar was 53 mg/deciliter (dl). On 1/4/25 at 8:39 p.m. vital signs indicated R3's blood sugar was 54 mg/dl. On 1/6/25 at 5:14 a.m. a progress note indicated R3's blood sugar was 77, resident was alert to self and on call provider gave order to recheck blood sugar (BS), vital signs and mental status in an hour and update the provider if it remained less than 75. On 1/6/25 at 7:37 a.m. vital signs indicated R3's blood sugar was 65 mg/dl. On 1/6/25 at 8:03 a.m. vital signs indicated R3's blood sugar was 65 mg/dl. R3's medical record lacked indication R3's provider was notified for blood sugars less than 75 on 1/4/25, and 1/6/25. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/8/25 at 10:49 a.m. licensed practical nurse (LPN)-A stated R3's BS checked on 1/6/25 was 65 at 7:37 a. m. by registered nurse (RN)-A, but he did not know if the provider was notified. On 1/8/25 at 1:11 p.m. nurse practitioner (NP)-A stated staff were instructed to call back the provider if R3's blood sugar remained low. She could not find anything in the system suggesting the facility called her back on 1/6/25 when R3's blood sugar did not improve. She also was not notified of R3's low blood sugar of 54 on 1/4/25. Staff were expected to follow the provider orders. On 1/8/25 at 1:29 p.m. RN-A stated she was new to the facility, so LPN-A agreed to help her with R3's care on 1/6/25. She reported R3's low blood sugar of 65 to LPN-A, but she did not call the provider. She thought LPN-A notified the provider since he had been caring for R3. On 1/8/25 at 2:54 p.m. RN-B stated she was the only nurse on the floor on 1/4/25, and recall caring for R3. R3's blood sugar of 5 had been reported to her, but she was so busy, and she forgot to notify the provider. On 1/9/24 at 12:12 p.m., the director of nursing (DON) stated staff were to follow the resident's care plan and the provider's orders. The facility policy Notification of Changes dated 3/24 directed the facility staff to make appropriate and timely notification to the physician and delegated non-physician practitioner when there is a change in the resident's condition that may require physician intervention.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48040 Based on observation, interview and document review, the facility failed to provide 1:1 supervision during meals to ensure a resident who was identified as a choking risk was supervised while eating for 1 of 3 residents (R2) reviewed for 1:1 supervision during meals. Findings include: R2's Admission Record dated 4/24/24 indicated R2's diagnoses included muscle weakness, dysphagia, and oropharyngeal phase. R2's quarterly Minimum Data Set (MDS) dated [DATE], indicated R2 had mechanical altered diet, required change in texture of food, and required staff supervision for all meals and drinks. R2's care plan dated 8/21/24, indicated R2 had potential alteration in nutrition related to dysphagia, oropharyngeal phase, and needed 1:1 supervision with meals with reminders to swallow foods and liquids. R2' Provider Orders dated 8/21/24 indicated regular diet mechanical soft texture, regular (thin) consistency fluids, 1:1 feeding and drinking, remind to swallow. No straws per speech therapist. On 1/7/25 at 12:53 p.m. R2 was observed in her wheelchair (W/C) in her room by herself eating ice cream. R2 fed herself the ice cream, and did not swallow what was in her mouth before she took more bites. R2 started coughing. R2 continued feeding herself the ice cream and started coughing continuously. No staff were providing 1:1 supervision. On 1/8/25 at 9:18 a.m. R2 was observed in her W/C in her room by herself. A bowl of oatmeal was on the bedside table. R2 fed herself the oatmeal, and did not swallow what was in her mouth before she took more bites. R2 started coughing. No staff were providing 1:1 supervision. On 1/8/25 at 9:29 a.m. R2 stated she tried the oatmeal and the sausage that were on her plate. They were not good, so she ate just a little. No staff were in the room to help her with her meals. On 1/8/25 at 9:35 a.m., nursing assistant (NA)-B entered R2's room, and asked R2 if she was done with her meal. NA-B removed the oatmeal, and left a small cup, and a water pitcher with a straw in it on the table, and left the room. On 1/8/25 at 2:04 p.m. NA-A stated R2 usually ate in the dining room, but yesterday morning she was vomiting in the dining room and wanted to go back to her room. He was aware R2 required supervision while she was eating, but staff got busy and did not stay with her. On 1/8/25 at 2:15 p.m. NA-B stated the care guide sheet directed R2 was to be supervised with all meals and drinks. She got busy today and was not able to provide 1:1 supervision while R2 was eating. When she heard R2 coughing, she reported to the trained medication aide (TMA)-A. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/9/25 at 11:14 a.m. speech therapist (ST)-A stated she recommended R2 to have 1:1 close supervision at all meals to prevent aspiration and choking. 1:1 supervision meant nursing staff were to sit with R2 when she received her meal until she was done eating. Staff was also to provide cues and reminders to swallow one bite at the time. If R2 did not have 1:1 supervision with meals, she could choke, aspirate, or get pneumonia. On 1/9/24 at 12:12 p.m., the director of nursing (DON) stated staff were to follow the resident's care plan and assist them per speech therapist recommendations. She said 1:1 supervision meant staff sit next to the residents when they were eating to remind them to swallow. On 1/9/25 at 2:27 p.m. NP-A stated R2 had to be supervised for all meals and drinks. Failure to supervise R2 during meals time would put her at risk for aspiration. The facility policy Activities of Daily Living (ADLs) dated 3/31/23 directed staff to provide a person-centered care and services including supervision for each resident related to resident's physician orders.