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	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

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47083 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 [DATE] 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 [DATE] 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. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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** 47083 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 [DATE] indicated R1 had a diagnosis of cerebral infarction (stroke). The MDS indicated he 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 [DATE] 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 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. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 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.