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	03/27/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to follow established infection control practices for 1 of 3 residents (R4) reviewed for hand hygiene when staff failed to perform hand hygiene and change gloves while performing care.Findings include: During an observation on 3/26/26 at 10:08 a.m., registered nurse (RN)-A and the nurse practitioner (NP) performed wound care for R4. RN-A was wearing gloves when she removed the wound dressing from R1's left heel, then removed the dressing from R1's right heel, sprayed both wounds with wound cleanser, wiped R1's left heel with gauze, and then used a clean gauze pad to wipe R1's right heel. RN-A failed to remove her gloves and perform hand hygiene following disposing of the dressings and between cleaning R1's left and right heel. R1's admission Minimum Data Set (MDS), dated [DATE], indicated she had diagnoses of multiple rib fractures, heart failure, dementia, anxiety, had a pressure ulcer, was cognitively intact, and required staff assistance with cares and transfers. R1's care plan, dated 2/23/26, indicated she had pressure ulcers on her left and right heels, followed by wound care. During an interview on 3/26/26 at 11:03 a.m., RN-A stated hand hygiene and changing gloves was necessary after removing wound dressings and between providing care for each wound to reduce potential spread of infection. During an interview on 3/26/26 at 10:42 a.m., the NP stated hand hygiene and changing gloves was expected after cares and between wounds because infection could ensue. During an interview on 3/26/26 at 11:24 a.m., the director of nursing (DON)/infection prevention (IP) nurse stated gloves should be changed when going from dirty to clean areas and hand hygiene should be performed after removing gloves by using hand sanitizer or washing with soap and water to prevent infection. The facility Wound Care Treatment Procedure, dated 2/2024, indicated:Remove the previous dressing.Dispose of previous dressing in designated container.Remove your gloves and complete hand hygiene.Clean the wound according to the physician's orders.Remove gloves, dispose of them in the designated container, and complete hand hygiene.Apply clean gloves and complete the residents dressing change while following the provider's order.

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.

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