

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  04/24/2024
NAME OF PROVIDER OR SUPPLIER  The Estates at Twin Rivers LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48013</b></p> <p>Based on observation, interview and document review, the facility failed to ensure residents were comprehensively assessed for self-administration of medications for 1 of 1 resident (R21), reviewed and observed for self-administration of medications.</p> <p>Findings include:</p> <p>R21's significant change Minimum Data Set (MDS) dated [DATE], identified R21 had intact cognition and was independent with all activities of daily living (ADLs). R21's diagnoses included stroke, hemiplegia (left side), depression, asthma, muscle wasting and atrophy, muscle weakness, cellulitis, and long-term use of anticoagulants.</p> <p>During record review on 4/24/24, R21's electronic health record (EHR) indicated a signed orders completed by certified nurse practitioner (CNP)-A on 4/12/24 directinh staff to leave melatonin and trazadone at bedside when giving R21 medications and R21 would take medications when ready for bed. Order lacked parameters of time when medications could be left.</p> <p>R21's EHR lacked assessment for self-administration of medications.</p> <p>During interview on 4/24/24 at 9:15 a.m., trained medication aide (TMA)-A stated if a resident could self-administer medications that there would be an order on the MAR. TMA-A stated she had left R21's scheduled melatonin and trazadone beside several times, especially before she left at the end of her shift.</p> <p>During interview on 4/24/24 at 10:32 a.m., director of nursing stated in order for a resident to be able to self-administer medications, an assessment needed to be completed to ensure that the resident is able to safely administer and store medications. DON stated R21 does not have an order to self-administer medications. DON stated that she was not aware of the order from the provider on 4/12/24 stating the okay to leave melatonin and trazodone bedside. DON confirmed order was entered into R21's EHR and stated that an assessment needed to be completed with R21 first before initiated and that assessment was not completed. DON stated she was the one who completed those assessments and staff were suppose to update her when order from provider is received regarding self-administration of medication.</p> <p>(continued on next page)</p>

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
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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility Self-Administration of Medications policy, dated 2/2024, indicated residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. The interdisciplinary team considers the following factors when determining whether self-administration of medications is safe and appropriate for the resident:</p> <ul style="list-style-type: none"> <li>A. The medication is appropriate for self-administration.</li> <li>B. The resident is able to read and understand medication labels.</li> <li>C. The resident can follow directions and tell time to know when to take the medication.</li> <li>D. The resident comprehends the medication's purpose, proper dosage, timing, signs of side effects and when to report these to the staff.</li> </ul> <p>If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan. The decision that a resident can safely self-administer medications is re-assessed periodically based on changes in the resident's medical and/or decision-making status.</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48013</b></p> <p>Based on observation, interview and document review, the facility failed to ensure reasonable accommodation of need related to repositioning device for 1 of 1 resident (R21) reviewed for bed rails.</p> <p>Findings include:</p> <p>R21's significant change Minimum Data Set (MDS) dated [DATE], identified R21 had intact cognition and was independent with all activities of daily living (ADLs). R21's diagnoses included stroke, hemiplegia (left side), depression, asthma, muscle wasting and atrophy, muscle weakness, cellulitis, and long-term use of anticoagulants.</p> <p>During observation and interview on 4/22/24 at 6:17 p.m., R21 did not have bed rails on bed. R21 stated he had chronic right shoulder pain, used to have bed rails in room one and have asked several times for bed rails to be put on bed in room two to assist him with repositioning and/or getting in and out of bed due to pain.</p> <p>During observation on 4/23/24 at 9:30 a.m., R21's bed did not have bed rails on bed.</p> <p>During observation on 4/24/24 at 8:29 a.m., R21's bed did not have bed rails on bed.</p> <p>During record review on 4/23/24, R21 was assessed for bed rails on 3/16/24, with bed rails being installed to bed in room one. R21 moved from room one to room two on 4/1/24 and bed rails were never installed on bed in room two. R21 had the proper assessment and orders for bed rails in electronic health record (EHR) both completed on 3/16/24.</p> <p>During interview on 4/24/24 at 9:15 a.m., TMA-A stated R21 was independent with transfers and utilized bed rails to roll in bed and to get up from bed.</p> <p>During record review on 4/24/24, maintenance request log from the past 30 days was reviewed with no work order for installing bed rails to bed in room [ROOM NUMBER].</p> <p>During interview on 4/24/24 at 10:32 a.m., director of nursing (DON) stated when a resident moved to a new room, their original bed usually gets moved with the resident. If bed does not move with resident, a work order is placed with maintenance to have bed rails installed on new bed. DON confirmed that R21 did not currently have bed rails on bed and that R21 did have orders and the assessment to have and properly use the bed rails. DON stated bed rails are important for the resident for ease of mobility, independence and to assist with pain management.</p> <p>Bed rail policy was requested and was not received.</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>46943</p> <p>Based on interview and document review, the facility failed to ensure the services of a registered nurse (RN) were available onsite for 8 consecutive hours seven days a week. This had the potential to affect all 30 residents who reside at the facility.</p> <p>Review of the facility staffing schedules dated 10/1/23 through 12/31/23, identified there was not eight consecutive hours of RN coverage for 10/1/23, 10/8/23, 10/14/23 and 10/15/23.</p> <p>When interviewed 4/24/24 at 8:09 a.m., trained medication aide (TMA)-A stated there were only two licensed nurses employed with the facility which resulted in having to utilize agency licensed nurses. TMA-A stated she was unaware of any day or date when a registered nurse was unavailable for eight consecutive hours and verified a licensed nurse was always on duty. TMA-A stated she was unaware of any situation in which a resident needed cares from an RN and had not received them.</p> <p>When interviewed on 4/24/24 at 8:45 a.m., the administrator verified there was no RN on for eight consecutive hours on 10/1/23, 10/8/23, 10/14/23 and 10/15/23. The administrator stated the facility policy and practice was to have a RN on duty in the building eight consecutive hours but had call-ins for those four dates so only a licensed practical nurse (LPN) was on duty. The administrator stated after the call ins on those dates the facility now books two RNs for open shifts in case one calls in.</p>		

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<p>F 0912</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46943</p> <p>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 nine residents (R1, R187, R12, R16, R5, R23, R18, R6 and R27) who currently resided in these rooms.</p> <p>Findings include:</p> <p>During the entrance conference on 4/22/24 at 11:42 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.</p> <p>The following double resident rooms did not meet the required minimum square footage per resident:</p> <p>room [ROOM NUMBER] = 150 square feet, or 75 square feet per resident (R12).</p> <p>room [ROOM NUMBER] = 152.5 square feet, or 76.25 square feet per resident (R187).</p> <p>room [ROOM NUMBER] = 150 square feet or 75 square feet per resident (R18).</p> <p>room [ROOM NUMBER] = 150 square feet or 75 square feet per resident (R23).</p> <p>room [ROOM NUMBER] = 150 square feet or 75 square feet per resident (R1).</p> <p>room [ROOM NUMBER] = 150 square feet or 75 square feet per resident (R6).</p> <p>room [ROOM NUMBER] = 150 square feet or 75 square feet per resident (R5).</p> <p>room [ROOM NUMBER] = 150 square feet or 75 square feet per resident (R16, R27).</p> <p>04/22/24 at 12:46 p.m., R6 (room [ROOM NUMBER]) stated currently the room is meeting his needs as he has no roommate and is utilizing all of 150 square feet to store some of his personal items including a power wheelchair.</p> <p>04/22/24 at 1:12 p.m., R5 (room [ROOM NUMBER]) stated he is utilizing only his side of the room and has no concerns with the amount of space he has.</p> <p>04/22/24 at 7:41 p.m., R12 (room [ROOM NUMBER]) stated currently the room is meeting her needs as she has no roommate and is utilizing all of 150 square feet to store some of her personal items.</p> <p>04/23/24 at 3:53 p.m., R16 (room [ROOM NUMBER]) stated he is utilizing only his side of the room and has no concerns with the amount of space he has.</p> <p>04/22/24 at 7:46 p.m., R18 (room [ROOM NUMBER]) stated currently the room is meeting her needs as she has no roommate.</p> <p>(continued on next page)</p>

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<p>F 0912</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>04/23/24 at 3:53 p.m., R27 (room [ROOM NUMBER]) stated he is utilizing only his side of the room and has no concerns with the amount of space he has.</p> <p>04/22/24 at 7:38 p.m., R187 (room [ROOM NUMBER]) stated currently the room is meeting his needs as he has no roommate and is utilizing all of 150 square feet.</p> <p>During interview on 4/23/24 at 3:56 p.m., trained medication aide (TMA)-A stated that some rooms are tight with space in the rooms that have two residents. TMA-A stated she had not heard any complaints from any residents regarding the size of the room and/or complaints about roommate.</p> <p>47638</p> <p>48013</p>