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	05/23/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to implement interventions to maintain a dignified appearance related to the failure to properly secure urinary leg bags for 1 of 1 residents (R28) reviewed for urinary catheter. Findings include: R28's admission Minimum Data Set (MDS) dated [DATE], indicated R28 had moderate cognitive impairment and required assistance with activities of daily living (ADLs) including dressing, grooming, bathing, and transfers. R28 was noted to have an indwelling catheter. R28's medical diagnoses included an artificial opening of the urinary tract (nephrostomy tubes-tubes which drain urine from the kidneys), benign prostatic hyperplasia (a non-cancerous enlargement of the prostate gland which can lead to various urinary problems in men), renal insufficiency (a condition which the kidneys are not functioning at their full capacity), urinary tract infections, diabetes (a group of diseases which affects how the body uses blood sugar), specialized disorders of the bladder, and dementia. R28's care plan printed 5/21/25, identified R28 was on enhanced barrier precautions related to nephrostomy bag, was a fall risk related to nephrostomy tubes (a tube inserted through the skin directly into the kidney that drains urine when the urine is unable to leave the body normally), had alteration in mobility related to nephrostomy tubes, and had self care deficit related to bilateral nephrostomy tubes. R28's care plan lacked direction as to management of the nephrostomy bags, cares to be provided to the sites, and direction as to securing of nephrostomy bags for resident to maintain dignity and prevent falls. The Group one (1) CNA (certified nursing assistant) work list, updated 5/21/25, identified R28 was dependent with toileting and had nephrostomy tubes. The list lacked any further direction to staff as to how provide cares for the nephrostomy tubes and bags. On 5/19/25, at 3:59 p.m., R28 was observed seated in his wheelchair near the Transitional Care Unit (TCU) nurses station. R28 was positioned near the medication (med) cart and the wall. R28 was observed to have a urinary leg bag coming out of his left pant leg laying on the floor, with R28 observed dragging it as he self propelled his wheelchair. NA-A stopped to assist R28, but then stepped away to wash hands as had not been wearing gloves. NA-A requested licensed practical nurse (LPN)-B provide assist to R28. LPN-B proceeded to push the resident NA-A was assisting to her room, leaving R28 near the nurses station with the leg bag on the floor. LPN-B then returned to assist R28 to his room to secure leg bag. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/19/25 at 5:17 p.m., an interview was completed with LPN-B, she had assisted R28 to his room and placed his leg bag back on his leg and tightened the strap. LPN-B stated the concern for leg bag being on the floor was related to bacteria and germs. On 5/22/25 at 10:36 a.m., R28 was observed as he received personal cares. NA-B proceeded to secure nephrostomy bags to R28's legs. The band NA-B was using was a wider width, approximately two inches, such as a band used to secure a catheter tube to the upper thigh. NA-B identified when using a leg bag, there were usually straps which threaded through the leg bag, however, these straps were not available. NA-B stated the straps provided were too large for the bags to secure well to R28's legs. NA-B stated the straps did not work well to maintain the leg bag in place, and the leg bags slid down, at times out of pant legs. NA-B stated it was a concern when the leg bags slid down as the bag would pull on the tubes (nephrostomy tubes). NA-B stated they needed to make sure the (nephrostomy) dressings remained in place and free from drainage. NA-B stated she had asked about different straps, but this is what they give us. During interview on 5/22/25 at 11:32 a.m., LPN Clinical Coordinator (CC) stated R28's leg bags should be secured properly on his legs and should not be on the floor due to concerns with dignity, as well as concerns for infection control. CC stated the leg bags should be out of view. CC stated it was her expectation if a leg bag was observed to be laying on the floor, they should be immediately assisted to their room to secure the bag properly. CC stated they have tried a variety straps, they have tried to find the best fit. CC stated she was unaware the current strap was not working effectively. During interview on 5/22/25, at 11:50 a.m., director of nursing (DON) stated the urinary leg bag should not be on the floor. DON stated the leg bag should be secured. She added, they typically came with a strap for the top and for the bottom, and stated she was unsure why this was not being used. DON identified concerns for infection control as well as for dignity of the resident. A facility policy, Indwelling Catheter Care Procedure, dated 7/21/23, was provided upon request for care of urinary drainage bag management policy. This policy lacked information as to management of urinary drainage bag, including placement and process to secure, to ensure privacy and dignity. Upon request for a policy for maintaining resident dignity, the facility provided the document Combined Federal and State [NAME] of Rights, revised 6/18/19. Within the document, it identified the facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The documented identified the facility must protect and promote the rights of the resident.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to obtain proper consent for use of psychotropic medications (a drug which affects behavior, mood, thoughts or perception) for 1 of 5 residents (R35) reviewed for unnecessary medications. Findings include: R35's admission Minimum Data Set (MDS) dated [DATE], indicated R35 had impaired cognition. R35 was noted to receive assist with activities of daily living (ADLs) including dressing, grooming, bathing, and mobility. R35's medical diagnoses included unspecified encephalopathy (brain disease, damage, or malfunction which encompasses a range of conditions that could cause brain dysfunction, which might manifest as confusion, memory loss, personality changes, or severe symptoms like coma), cancer, atrial fibrillation (an abnormal heart rhythm which has been known to lead to complications including stroke, blood clots, and heart failure), hypertension (high blood pressure), arthritis (inflammation of joints), dementia, anxiety, depression, visual hallucinations (seeing something that is not there), adjustment disorder with anxiety, chronic pain syndrome, and fibromyalgia (symptoms of widespread chronic pain, headaches, depression and other symptoms). R35's care plan printed 5/22/25, indicated R35 had alteration in cognition related to confusion, disorientation to place and time. Poor insight to her deficits or cognitive loss. Poor historian. Sundowning type behaviors of crying and calling out. Has decreased in intensity since admission. The problem statement identified R35 had the diagnosis of major neurocognitive disorder, with behavioral disturbance, encephalopathy due to medical illness (various infections), visual hallucinations, and low vision due to retinal pigmentation disease. The care plan directed staff to follow recommendations from mental health provider. The care plan lacked indication of medications used to aide with mood state and behavior. R35's Medication Administration Record (MAR), printed 5/20/25, indicated R35 received the following medications: - lorazepam 0.5 milligrams (mg) by mouth one time a day for agitation. Start date of 4/3/25. (benzodiazepines used for anxiety). - lorazepam 0.5 mg by mouth every four hours as needed for anxiety or agitation for six months. Start date 4/3/2025. - risperidone 1 mg by mouth at bedtime for agitation/delirium. Start date of 5/5/25. (antipsychotic- works by changing certain signals in your brain which affect how you feel and act). - risperidone 0.5 mg by mouth two times a day for delirium/ agitation. Start date 5/5/25. R35 was noted to receive Lorazepam on 13 occasions in April, with results marked as effective on 10 of the 13 occasions used. This was noted to be used on two occasions in May (5/9/25, 5/13/25) with effective results on each occasion. The May MAR was reviewed for the dates of 5/1/25-5/20/25. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R35's medical record lacked indication informed consent had been received from R35's responsible party upon admission to the facility, as well as with change of medication dosing/frequency. On 5/20/25 at 3:52 p.m., R35 was observed in her room, resting on her bed, with blanket in place. R35 had a visitor in her room, playing her guitar, and singing to resident. Resident was observed to be awake and was interacting with her visitor. During interview on 5/22/25 at 1:46 p.m., the director of nursing (DON) stated completion of an informed consent was typically completed within the first week following admission if a resident was admitted on a psychotropic medication. DON stated this was typically completed by the floor nurse, however, if it had not been completed within that time frame, it was followed up on by either the licensed practical nurse, clinical coordinator (CC) or the DON. DON stated consents were to be obtained when new medications were added, as well as updated when changes were made in dosage and frequency of existing meds. A request was made for the documentation of informed consent for both risperidone and lorazepam, which were unable to be located in the medical record. DON stated she also did not find them uploaded on the record. DON stated it was important to receive informed consent for psychotropic medications, as they are medications which have the potential to have more adverse (negative) side effects than other medications, and it is important to notify the responsible part of the possible side effects. The facility policy, titled Psychotropic Medication Use Policy, created 4/25, identified the facility would a. Obtain informed consent from the resident and/or resident representative and document education, information regarding the medication indication and directions for use, side effects and potential adverse consequences, risks and benefits of the medication and resident choice. b. Discuss any advance directives that the resident has formulated to provide care consistent with resident choice. c. The resident and/or responsible party will be notified regarding dose changes. d. This will be documented in the progress notes. e. Consents and any psychotropic medications will be reviewed quarterly at resident care conferences.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the failed to facilitate resident preferences for bathing and meals for 1 of 1 resident (R27) reviewed for choices. Findings include: R27's admission Minimum Data Set (MDS) dated [DATE], indicated R27 was cognitively intact. The assessment identified R27 received assistance with activities of daily living (ADLs) including dressing, grooming, bathing, mobility, and incontinence care (managing of bowel and bladder). The MDS identified it was very important to R27 to choose between a tub bath, shower, bed bath, or sponge bath, and somewhat important to choose what clothes she wished to wear. R27's medical diagnoses included multiple sclerosis (MS), malnutrition (an imbalance of energy and nutrients consumed), thrombocytosis (increase platelet count), pseudobulbar affect (a condition characterized by uncontrollable and inappropriate episodes of laughing or crying, often disconnected from person's actual emotion state). R27 received routinely schedule pain medication, as well as availability of additional pain medication as needed. R27's care plan with a print date of 5/21/25, identified R27 had the potential for alteration in nutrition related to MS, severe protein calorie malnutrition and dyspepsia (indigestion). The goal for R27 was for her to meet estimated nutrient needs, and to either maintain weight or gain weight to ideal body weight range. The care plan directed staff to provide diet as ordered by the provider. Staff were also encouraged to monitor food and fluid intake per facility protocol and encourage adequate fluid intake. The care plan directed staff to offer fluids and snacks between meals. R27's care plan also identified R27 had a self care deficit related to post surgical status, weakness and MS. The goal indicated R27 will accept assistance with self cares and will be dressed, groomed, and bathed per preferences. The care plan directed staff to follow through with instructions provided by occupational therapy. Staff were also directed to provide with assist of one with dressing and bathing. R27's care plan also identified R27 had alteration in mobility related to post surgical status, weakness and MS. The care plan directed staff R27 was to receive physical therapy (PT) as per doctors orders, and instructed staff to follow PT instructions. The care plan indicated R27 was to receive assist with movement in and out of bed and was to receive assist of one with transfers, however lacked further instructions. Although R27's care plan indicated R27 was on enhanced barrier precautions (increase precautions implemented to prevent the spread of infection) related to surgical incisions, the care plan lacked indication as to how the surgical sites were to be managed, additionally lacked any restrictions in showering related to incisions. The Nursing Assistant care sheet dated 5/21/25, indicated R27 was to receive assistance to transfer with an EZ stand (a mechanical lift to aid in transfers) and did not ambulate. The NA care sheet outlined R27 required assist of one with dressing, bathing, toileting, and required set up for grooming and eating. The care sheet provided no additional instructions to staff for provision of care. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/19/25 at 5:48 p.m., R27 was served her evening meal. Family member (FM)-A was present in room and asked R27 what she was having for supper. R27 stated she was unaware of what she was having for supper, as she had not ordered the meal selection. R27 uncovered plate and stated it was a tuna fish sandwich and she did not wish to eat this. R27 observed the coffee came without sugar and cream, which she has requested be with meals, and there were also no straws on the tray for resident use with all beverages. R27 placed her call light on to request missing items on tray. R27 stated she was unaware of what the food choices were as she had no menu in her room. R27 stated there was an alternate menu available, however, the evening meal must be ordered by 3:00 p.m. in order to receive this. R27 stated she was unsure what alternatives were available or how to order them. R27 stated she had no special diet, and had been struggling with weight loss. R27 stated she was to receive two supplements per day to help nutrition, but was unsure she had received them consistently. R27 was noted to have liquid protein supplement drinks in her room, however, R27 they were brought in for her by her friend. On 5/19/25 at 5:58 p.m. R27 expressed frustration she had not received a bath/shower since she had arrived. FM-A affirmed that R27 had doctor's appointments last week and wished to receive a bath/shower before going to her appointments, however, had not received assistance. R27 stated an unidentified certified nursing assistant (NA) came in to provide assistance with a sponge bath, however, R27 wanted a shower to be able to wash her hair as it had not been washed in the weeks since admission. R27 stated the NA put it down that she refused her bath. R27 reported when she asked when she could receive a shower, was told she had to wait for the next shower day. R27 stated Nobody knows how to do a shower. R27 stated neither PT/OT had worked with her regarding the transfer required for completing a bath and shower. FM-A stated R27's hair had not washed since admission and R27 had expressed desire to shower prior to appointments due to lack of bathing since admission, and desire to be clean for medical appointments. On 5/20/25 1:01 p.m., R27 had been delivered her noon meal. R27 stated the tray lacked sugar and cream for coffee, as well as straws to use with her beverages. R27 stated she had requested this from staff however, they had not returned with the items. R27 stated this was the same case with breakfast. A tray slip was observed on resident tray, which identified R27 requested sugar and cream for coffee, and straws for all beverages. R27 stated she was unaware she was scheduled to receive a bath this afternoon, however, stated she would like her hair washed and linens changed. On 5/20/25 at 4:10 p.m., R27 was observed in her room. R27 stated the shower was completed and hair was washed twice. R27 identified the linens were placed back on bed properly, however, noted they had not been changed. On 5/20/25 at 3:49 p.m., an interview was held with both registered dietitian (RD) and regional culinary director (RCD), about availability of menus and the Bistro option for alternates. RD stated residents were provided with a regular menu and bistro menu upon admission. RD was unsure as to when updated menus were provided to those who remained in their rooms for meals. RD and RCD both stated the Bistro menus were available in the dining room for ordering alternatives. RD was unsure if Bistro menus were delivered to rooms for those who did not dine in the dining room. RD stated if there were specific requests by a resident, this was indicated on the tray slip and these requests should be facilitated by the dietary staff. R27's tray slip was reviewed at time with RD, and it was noted although the preferences/requests were on the dietary slip, it was not identified in the place where it was normally listed. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 5/21/25 at 9:27 a.m., physical therapy assistant (PTA)-A stated she participated in the therapy for R27. At present time, PTA-A stated they were working with R27 on core strength, transfers into and out of bed, and in/out of wheelchair. PTA-A stated they were also working on range of motion (ROM) for lower extremities and joint mobility. PTA-A stated R27 has been an EZ Stand transfer for nursing staff since 4/29/25. Occupational therapist (OT)-A joined the conversation and stated both PT/OT are working with wheelchair positioning. OT-A stated OT-A does not have a specific goals for showers. OT-A stated she had not been informed by nursing staff of any concerns regarding showers, therefore, that had not been part of the therapy plan. During interview on 5/21/25 at 10:08 a.m., the clinical coordinator (CC)-A stated R27 had received assistance to complete bathing on 5/20/25. CC-A stated R27 was unable to complete showers/baths prior to that time related to incisions on her stomach following a laparoscopic procedure (A procedure completed with a scope through several small incisions on the abdomen). CC-A stated R27 required clearance from the medical provider because of the laparoscopic incisions. CC-A stated they had offered to complete a shower on an earlier occasion however, R27 had declined the shower related to the time of day. CC-A stated if it is not their shower day, staff were instructed to accommodate the request if we had extra time. CC-A stated she would expect staff would have offered it multiple times until she agreed to it. CC-A stated lack of shower, or washing of hair, for extended time would not feel very good. Residents were assigned a time for bathing/showering based on their room placement. They tried to work with residents a different day/time was requested however, it was not always possible. CC stated she was unaware of any concerns regarding bathing status until resident care conference on 5/15/25. CC stated R27 had received sponge baths since her admission however, she was unsure if her hair was washed. CC stated when there were recommendations for OT/PT this was relayed to staff. CC stated if staff had concerns with provision of care, PT/OT was consulted. CC stated when trays were delivered to residents in their room, it would be her expectation for staff to respond to requests made by residents upon receipt of their tray. During interview on 5/21/25 at 4:54 p.m., the director of nursing (DON) stated baths were scheduled on a weekly basis. This was completed based on their designated time based upon room placement. DON stated if the resident did not care for the time slot, there may be some flexibility in adjusting it, however, that was not always possible. DON stated We try to be flexible but there is only so much wiggle room in that. If a bath was refused, and it was requested on another day, and the aides had time, it may occur, otherwise the next bath/shower would be completed the following week on the routinely scheduled time. Upon inquiring why a shower was not completed for R27, DON stated that if the person had a laproscopic surgery, they would not have a shower if there were restrictions placed per the doctor's orders upon admission or following the procedure. If there were not restricted orders, the individual could receive a shower. A request was made for verification of orders in place upon admission to abstain from showers, however, DON failed to provide order which identified shower restrictions were in place upon admission. Upon review of R27's After Discharge Orders, from 4/28/25, the notes indicated resident had a laparoscopic procedure, however, had not restricted resident from receiving showers A review of the standing orders, filed 5/20/25 electronically, lacked indication for shower restrictions for those with laparascopic surgical sites. The document did refer to the policy Skin and Wound Management. The document, not labeled with R27's name, was identified as being signed by the provider 2/1/25. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the policy, Skin Assessment and Wound Management, dated 2/25 lacked indication as to management of a laparoscopic surgical site. The facility policy, titled Activities of Daily Living (ADL's) Maintain Ability Policy, dated 3/31/23, was reviewed. The statement of intent reads as follows: It is the policy of the facility to specify the responsibility to create and sustain an environment that humanizes and individualizes each resident ' s quality of life by ensuring all staff, across all shifts and departments, understand the principles of quality of life, and honor and support these principles for each resident; and that the care and services provided are person-centered, and honor and support each resident ' s preferences, choices, values and beliefs. Upon review of the procedure, the policy indicated: The facility will provide care and services for the following activities of daily living: . d. Dining-eating, including meals and snacks, . The policy also identified: A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, . A policy was requested for resident choices and food preferences, but was not received.

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure both recertification survey results, as well as additional complaint investigations, were available for review. This had the potential to affect all 32 residents residing in the facility, as well as family, visitors and staff. Findings include: On 5/19/25 at 2:09 p.m., a folder, titled Twin [NAME] Survey Results, was observed outside the Social Services office. This folder contained the survey results from the recertification 4/22/24 through 4/24/24. The folder also contained the complaint investigation survey results from 10/17/24, 1/9/24, and 1/21/25. On 5/19/25 at 2:15 p.m., the administrator stated she was responsible for managing the posting of survey results. Administrator stated the complaint investigations were in the file for review. Administrator stated she was aware the 2567 (Formal documentation of the recertification process findings, as well as the outcome of the survey investigations) was to be available for review by residents, families, staff and visitors. On 5/21/25 8:08 a.m., licensed social worker (LSW) stated on 5/19/25, she had removed some survey results from the folder prior to writer's review of the folder as she had seen the papers in the folder were in disarray. LSW stated at this time, all of the papers from investigations completed were returned to the administrator for placement in survey results folder. Administrator walked by at that time, and surveyor and administrator returned to the administrator's office for review of the documents. The survey folder was obtained from administrator at that time for comparison to surveys completed, as documented in Aspen Central Office (ACO-an online computerized federal documentation site which contains the surveys completed for facilities, including both recertification and complaint investigations). On 5/21/25, at 8:10 a.m., a review was completed of ACO documentation. The last facility recertification survey prior to this was completed 4/24/24. Upon review of the complaint investigations from the last recertification, it was identified documentation was present in ACO for the following dates: 4/30/24, 6/6/24, 7/30/24, 11/7/24, 10/17/24, 12/18/24, 1/9/25, 1/21/25, 2/18/25, 2/19/25 and 5/1/25. Upon review of the survey results in ACO, it was noted the following investigations had deficiencies cited: 10/17/24, 11/27/24, 1/9/25, 1/21/25, 2/18/25, 2/19/25, and 5/1/25. Of these surveys, the survey results were only present in the facility survey folder for the following dates: 10/17/24, 1/9/24, and 1/21/25, as had been noted on 5/19/25, at 2:09 p.m On 5/21/25, at 8:41 a.m. an interview was held in follow up with the administrator. At this time, the adminstrator stated she did not need to have the additional dates provided as had not previously printed out, or placed, any additional survey information in the survey folder aside from what was outlined above. The administrator stated she was aware the 2567's were required to be available for review from all surveys, including recertifications and complaint investigations. (continued on next page)

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	An untitled, undated document was received upon request for the policy for posting of survey results. This document, identified as Minnesota Statute § 144A.10, Subdivision 3, mandated that skilled nursing facilities (SNFs) posted correction orders and notices of noncompliance in a conspicuous and readily accessible place within the facility. The document further identified this requirement ensured transparency and allowed residents, families, and the public to be informed about the facility's compliance status. The policy identified facilities were required to post copies of each correction order and notice of noncompliance received after their most recent inspection or reinspection.

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	05/23/2025

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

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to consistently provide clean bed linens for 1 of 1 residents (R27) reviewed for choices and provision of assistance with activities of daily living (ADLs). Findings include: R27's admission Minimum Data Set (MDS) assessment dated [DATE], indicated R27 was cognitively intact. The assessment identified R27 received assistance with ADLs including dressing, grooming, bathing, mobility, and incontinence care (managing of bowel and bladder). R27's medical diagnoses included multiple sclerosis (MS) and malnutrition (an imbalance of energy and nutrients consumed. R27's care plan dated 5/2/25, identified R27 had a self care deficit related to post surgical status, weakness and MS. The goal indicated R27 will accept assistance with self cares and will be dressed, groomed, and bathed per preferences. R27's care plan also identified R27 had alteration in mobility related to post surgical status, weakness and MS. On 5/19/25 at 5:58 p.m., R27 expressed frustration she had not received a bath/shower since she had arrived and expressed frustration regarding lack of change of bed linens. R27 stated she was unsure as to when the bedding had last been changed. R27 routinely remained in bed for meals due to mobility concerns. During interview on 5/20/25 at 1:01 p.m., R27 stated she was unaware she was scheduled to receive a bath this afternoon however, stated she would like her hair washed and linens changed. R27's bottom sheet had come off at the foot of the bed, and linens were noted to have small bread like crumbs and some tannish colored coffee spills on the top sheet. R27 ate all meals sitting in bed due to mobility concerns. On 5/20/25 at 3:10 p.m., it was noted R27's bedding was placed back on the mattress and was folded back, however, linens had not been changed, as evidenced of by tannish colored spots on bedding previously observed. On 5/20/25 at 4:10 p.m., R27 was observed back in her room. R27 stated the shower was completed and hair was washed twice. R27 identified the linens were placed back on bed properly, however, noted they had not been changed as the same tannish spots previously noted remained in the same location on the sheets. During interview on 5/21/25 at 10:08 a.m., the clinical coordinator (CC)-A stated linens should have been changed while she was in the shower. CC-A stated linen changes were done routinely on bath days, and in between as indicated if they were soiled. The facility policy, titled Activities of Daily Living (ADL's) Maintain Ability Policy, dated 3/31/23, was reviewed and the statement of intent reads as follows: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	It is the policy of the facility to specify the responsibility to create and sustain an environment that humanizes and individualizes each resident's quality of life by ensuring all staff, across all shifts and departments, understand the principles of quality of life, and honor and support these principles for each resident; and that the care and services provided are person-centered, and honor and support each resident ' s preferences, choices, values and beliefs. The policy lacked information regarding maintaining a clean, hygienic environment for residents, including provision of fresh bath and bed linens. A facility policy for change of bed linens was requested and was not provided.

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure a baseline care plan was developed to ensure all care needs were adequately addressed for 1 of 1 residents (R29) reviewed for range of motion. Findings include: R29's admission Minimum Data Set (MDS) dated [DATE], indicated R29 experienced moderate cognitive impairment. R29 was identified to have functional limitation of range of motion on one side with impairment on one side. R29 required assistance with activities of daily living (ADLs), including dressing, grooming, bathing, and mobility. R29's medical diagnoses included sequalae of cerebral infarction (details of cerebral infarction (stroke-and its effects it can cause to the brain including, but not limited to, change in mobility, loss of movement of one side of the body, vision problems, memory loss and difficulty with problem solving, emotional and behavioral changes, and seizures), heart failure (a condition where the heart is not able to pump enough blood for the body's needs for blood and oxygen), hypertension (high blood pressure), diabetes (a group of diseases which affects how the body uses blood sugar), muscle weakness, difficulty in walking and unsteadiness of his feet. A review of R29's medical record was completed. R29 was admitted on [DATE] (Friday). R29's 48-hour care plan was initiated on 2/3/25 and locked (no further entries were allowed) on 2/14/25. R29's 48-hour care plan identified the following: Self-care deficit related to L(left) side(d) weakness, impaired vision: The following goals were identified for R29: Resident will accept assistance with self-cares. Resident will be dressed, groomed and bathed per preferences. The following interventions were also identified: Occupational Therapy (OT) per MD (medical doctor) order Follow OT instructions. Assist with bathing with assist of one. Assist with dressing (Specify) [There were no specific interventions identified with this.] Mobility: Alteration in mobility related to left (L) sided weakness and impaired vision. The following goals were identified: Resident will move safely within their environment. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The following interventions were outlined: Physical Therapy (PT) per MD order. Follow PT instructions. Assist with ambulation (Specify) [There were no specific interventions identified with this.] Assist with movement in bed and in/out of bed. [There were no specific interventions identified with this.] Assist with transfers with one to two assist. [The care plan lacked specification whether transfers were to be completed with one or two.] Fall Risk related to (L) side weakness, impaired vision: The following goals were identified: Resident will be safe and free from falls. The following interventions were included: Follow PT and OT instructions for mobility function. Follow resident specific fall prevention plan:(Specify) [There were no specific interventions identified with this.] Monitor and document on safety. Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter/remove any potential causes if possible. Educate resident/family/ caregivers/IDT (Interdisciplinary Team) as to causes. Alteration in elimination: The following goals were identified: Resident will be continent during waking hours. Resident will continue to have at least one (1) continent void daily (qd). Resident will be free from signs/symptoms of UTI (urinary tract infections). [The care plan lacked indication of what symptoms were to be monitored for.] The following interventions were identified: Assist of one (1) with toileting. Provide assistance with peri-cares morning (AM), bedtime (HS) and as needed (PRN). (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide incontinent products and assist to change PRN. Alteration in psychosocial well-being. Resident is adjusting to nursing home placement, change in routine, and care needs: The following goals were identified: Resident's psychosocial needs will be met. The following interventions were identified: Will monitor safety concerns and evaluate PRN: smoking, elopement, suicide risk etc Will monitor mood state, refer PRN. Will monitor and respond to unmet needs. Alteration in Cognition. On 12/4/24 Resident was psychologically assessed in hospital and was determined that resident has insight deficits in terms of his stroke and function. Resident DX cerebral infraction, hyperlipidemia, type 2 diabetes, essential hypertension, chronic heart failure. The following goals were identified: Resident will communicate his/her basic needs as able. The following interventions were identified: Allow resident time to communicate his/her needs/wants. Document changes in orientation. Alteration in mood and behavior. Resident has hx of visual hallucinations and hx of insomnia. Verbalizes sexual comments to female staff. Refuses medications. DX (diagnosis) cerebral infraction, hyperlipidemia (high level of cholesterol-lipids/fats in the bloodstream, type two (2) diabetes, essential hypertension, chronic heart failure: The following goals were identified: Resident will respond to interventions by staff to calm and redirect. Resident's mood/behavioral state will remain stable. The following interventions were identified: MDS section D/PHQ 9 will be conducted per regulation and PRN. Monitor and document mood state/behaviors upon occurrence. Non-Pharm (pharmacological-interventions completed which do not include medications). (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident that comments are inappropriate. Change subject to topic related to his family or therapy goals. Redirect prn. Provide emotional support, validation, and comfort measures prn. Resident will have an appropriate discharge plan. Resident will have appropriate discharge plan. Resident is at risk for long term care. Resident diagnosis (DX) cerebral infraction, hyperlipidemia, type 2 diabetes, essential hypertension, chronic heart failure. The following goals were identified for R29: Resident/family will make safe and appropriate decisions regarding d/c (discharge). The following interventions were indicated: Staff will make necessary referrals as needed in order to carry out resident's d/c goals. Resident is categorically a vulnerable adult while resident resides in a Skilled Nursing Facility. Resident is at risk for decreased cognitive and physical abilities related to diagnosis including: cerebral infraction, hyperlipidemia, type two (2) diabetes, essential hypertension, chronic heart failure. The following goal was identified: Resident will remain free from abuse and/or neglect through his next review. The following interventions were identified: Monitor for signs of emotional distress or mood and behavior changes. Safety monitoring will be implemented as needed to ensure residents safety (i.e. 15 min checks,1:1, etc.) Staff will continue to follow the facility vulnerable adult & abuse reporting policy. The local Ombudsman, Adult Protection, Police, and/or state/financial agencies will be notified of any suspected abuse or financial exploitation as needed. R29's MHM 48 Hour Baseline Care Plan, dated 2/1/25, identified several sections to record R29's needs and the care plan interventions which would be provided. However, the following sections of the care plan were left blank and not completed: Communication Nutrition (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Psychotropic Medication Use Respiratory Skin Hospice Dialysis Smoking and, Enhanced Barrier Precautions. The baseline care plan lacked indication R29 was a type two diabetic, with nutritional needs, insulin administration, and lacked instruction to staff for monitoring of blood sugars to be provided by staff. The care plan lacked direction to staff to monitor for signs and symptoms of hyper or hypoglycemia (High or low blood sugar). Additionally, although resident was identified as having visual impairment, the care plan lacked any goals or interventions regarding the impairment itself, only how it may increase potential for falls. During interview on 5/23/25 at 1:05 p.m., director of nursing (DON) verified R29's care plan had not been completed within 48 hours. DON stated this was to completed at the time of admission and was to have been completed within that time. This was to completed by the nurse who admitted the resident. DON stated the 48 hour baseline care plan was important and it determined what care was needed by the staff, and directed staff on how to complete the care. A facility policy was requested for the development of a 48-hour care plan, but was not received.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, interview and document review, the facility failed to revise resident care plans with updated interventions for 1 of 1 residents (R27) reviewed for choices and activities of daily. Findings include: R27's admission Minimum Data Set (MDS) assessment, dated 5/2/25, indicated R27 was cognitively intact. The assessment identified R27 received assistance with activities of daily living (ADL's) including dressing, grooming, bathing, mobility, and incontinence care (managing of bowel and bladder). The MDS identified it was very important to R27 to choose between a tub bath, shower, bed bath, or sponge bath, and somewhat important to choose what clothes she wished to wear. R27's medical diagnoses included multiple sclerosis, malnutrition (an imbalance of energy and nutrients consumed), thrombocytosis (increase platelet count), pseudobulbar affect (a condition characterized by uncontrollable and inappropriate episodes of laughing or crying, often disconnected from person's actual emotion state). R27 received routinely schedule pain medication, as well as availability of additional pain medication as needed. R27's care plan, print date of 5/21/25, identified R27 had alteration in mobility related to post hysterectomy (surgical removal of uterus), weakness, and MS (multiple sclerosis- a disease that causes breakdown of the protective covering of nerves. Multiple sclerosis can cause numbness, weakness, trouble walking, vision changes and other symptoms). This was initiated on 5/2/25. The care plan directed staff to follow ACP (Associated Clinic of Psychology) recommendation to offer reminders re: her options re: (regarding) transfers and offer of reassurance from staff. The care plan identified R27 was to receive physical therapy (PT) per medical doctor (MD) and to follow PT instructions. Staff were directed to assist with movements in bed and in/out of bed. Staff were directed to assist with transfers with assist of one. The care plan also identified R27 had a self-care deficit related to post hysterectomy, weakness, MS. The goal statement indicated resident will be dressed, groomed and bathed per preferences. The identified R27 was to receive occupational therapy (OT) per MD (medical doctor) and staff were directed to follow OT instructions. The care plan identified R27 was to receive assist of one with bathing and dressing. The care plan lacked information regarding resident's transfer into/out of wheelchair, wheelchair positioning, and amount of time to be up in wheelchair. Although the care plan indicated R27 was to be dressed, groomed, or bathed per preferences, the care plan lacked direction as to what R27 had expressed as her preference. The care plan lacked any direction as to work with R27 with transfers and mobility related to side effects of MS. Additionally, the care plan lacked direction to staff as to how bathing was to be completed, and how dressing changes were to be managed. R27 was admitted after she had undergone a laparoscopic hysterectomy and had four small surgical sites which were covered with dressings. A therapy communication from physical therapy, dated 4/29/25, indicated R27 was to be transferred with use of an EZ stand (a mechanical lift used to assist with transfers). The form indicated R27 was to be up in chair three times a day. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nursing assistant care sheet, updated 5/21/25, indicated R27 was to transfer with the EZ stand and did not ambulate. The care sheet also identified R27 received assist of one with dressing, bathing, and toileting. The care sheet indicated R27 received assist for set up for grooming and eating. The care sheet indicated R27 was able to make her needs known. The care sheet lacked direction to assist R27 up in the chair three times a day. The care sheet lacked any information as to any interventions to be implemented to make the transfers and mobility go easier. On 5/19/25 at 5:55 p.m., R27 stated the certified nursing assistants (CNA) don't know how to transfer, position, perform her cares, or move her due to her rigidity. R27 stated the staff were unsure how to transfer her to and from bed/wheelchair. R27 stated she had spastic rigidity (a response when it was difficult to flex joints related to the spasm). R27 stated if allowed time, she was able to relax and move as needed, however, stated were not allowing her the time and moved her quickly, when still displaying rigidity. On 5/21/25 at 9:27 a.m., occupational therapist (OT)-A stated they are working with R27 with wheelchair positioning. OT-A stated R27 was to be up in wheelchair daily for quality of life. On 5/21/25 at 10:08 a.m., licensed practical nurse (LPN), clinical coordinator (CC)-A stated physical therapy (PT) evaluated the safe way for R27 to transfer and move. This information was relayed to staff to implement. CC-A stated this information was to be on the care sheet so that staff were aware of how to care for R27. She was uncertain if R27's spastic rigidity was addressed in care plan, or care sheet. R27 was also on medication to help with spasms. CC-A stated most recent care conference was held on 5/15/25. CC-A stated at that time, R27 identified concerns regarding her hair not being washed, and not receiving a shower. Although this was identified on 5/15/25, and implemented on 5/20/25, the care plan and care sheet lacked indication of resident preference for bathing and desire to wash her hair. On 5/21/25 at 4:54 p.m., the director of nursing stated the care plan should be reflect resident preferences, as well as how care was to be delivered. DON stated the care plan was to be updated at the time changes implemented. DON stated this would include recommendations made by physical therapy. DON stated the care conferences were attended by CC-A. DON stated changes made to the care sheets were also to be reflected on the care plan, and should be completed at the same time. The care plan and care sheet should both accurately reflect what cares were to be performed by staff, as they direct staff as to what cares were to be performed. A request for the facility policy for care plan updates was requested but not received.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to provide routine bathing assistance for 1 of 1 residents (R27) reviewed for activities of daily living (ADLs). Findings include: Findings include: R27's admission Minimum Data Set (MDS) dated [DATE], indicated R27 was cognitively intact. The assessment identified R27 received assistance with activities of daily living (ADL's) including dressing, grooming, bathing, mobility, and incontinence care (managing of bowel and bladder). The MDS identified it was very important to R27 to choose between a tub bath, shower, bed bath, or sponge bath, and somewhat important to choose what clothes she wished to wear. R27's medical diagnoses included multiple sclerosis (MS), malnutrition (an imbalance of energy and nutrients consumed), thrombocytosis (increase platelet count), pseudobulbar affect (a condition characterized by uncontrollable and inappropriate episodes of laughing or crying, often disconnected from person's actual emotion state). R27 received routinely schedule pain medication, as well as availability of additional pain medication as needed. R27's care plan, with a print date of 5/21/25, identified that R27 had a self care deficit related to post surgical status, weakness and MS. The goal indicated R27 will accept assistance with self cares and will be dressed, groomed, and bathed per preferences. The care plan directed staff to follow through with instructions provided by occupational therapy (OT) and physical therapy (PT). Staff were also directed to provide with assist of one with dressing and bathing. R27's care plan also identified R27 had alteration in mobility related to post surgical status, weakness and MS. The care plan indicated R27 was to receive assist with movement in and out of bed and was to receive assist of one with transfers, however lacked further instructions. Although R27's care plan indicated R27 was on enhanced barrier precautions (increase precautions implemented to prevent the spread of infection) related to surgical incisions, the care plan lacked indication as to how the surgical sites were to be managed, additionally lacked any restrictions in showering related to incisions. The Nursing Assistant care sheet dated 5/21/25, indicated R27 was to receive assistance to transfer with an EZ stand (a mechanical lift to aid in transfers) and did not ambulate. The NA care sheet outlined R27 required assist of one with dressing, bathing, toileting, and required set up for grooming and eating. The care sheet provided no additional instructions. On 5/19/25 at 5:48 p.m., R27 and Family member (FM)-A were present in room. R27 expressed frustration she had not received a bath/shower since she had arrived. FM-A affirmed that R27 had doctor's appointments last week and wished to receive a bath/shower before going to her appointments, however, R27 was not assisted with this. R27 stated a certified nursing assistant (CNA) came in to provide assistance with a sponge bath, however, R27 wanted a shower to be able to wash her hair as it had not been washed in the weeks since admission. R27 stated the CNA put it down that she refused her bath. R27 reported when she asked when she could receive a shower, was told she had to wait for the next shower day. R27 stated Nobody knows how to do a shower. R27 stated neither PT/OT had worked with her regarding the transfer into the shower chair required for completing a bath and shower. On 5/20/25, 1:01 p.m. R27 stated she was unaware she was scheduled to receive a bath this afternoon, however, stated she would like her hair washed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/20/25, at 4:10 p.m. R27 was observed back in her room. R27 stated the shower was completed and hair was washed twice. R27 stated this was the first time her hair had been washed for approximately 3 weeks. During interview on 5/21/25, at 9:27 a.m. the physical therapy assistant (PTA) stated she participated in the therapy for R27. At present time, PTA stated they were working with R27 on core strength. PTA stated they were also working with R27 to be able to transfer into and out of bed, and in wheelchair. OT stated OT did not have a specific goals for showers, as they had not been informed by nursing staff of any concerns regarding showers, therefore, that had not been part of the therapy plan. During interview on 5/21/25, at 10:08 a.m. the clinical coordinator (CC)-A stated R27 had received assistance to complete bathing on 5/20/25. CC-A stated R27 was unable to complete showers/baths prior to that time related to incisions on her stomach following a laparoscopic procedure (A procedure completed with a scope through several small incisions on the abdomen). CC-A stated R27 required clearance from the medical provider because of the incisions. CC-A stated staff had offered to complete a shower on an earlier occasion, however, R27 had declined the shower related to the time of day. When asked if they had a second opportunity to receive a shower before the next scheduled bath day, CC-A stated if it was not their shower day, staff were instructed to accommodate the request if they had extra time. CC-A stated she would expect staff would have offered it multiple times until she agreed to it. CC-A stated lack of shower or washing of hair for extended time would not feel very good. CC-A stated residents were assigned a time for bathing/showering based on their room placement. When asked if resident's were allowed to choose an alternate time which worked better for them, CC-A stated they tried to work with residents, however, it was not always possible. CC-A stated she was unaware of any concerns regarding bathing status until resident care conference on 5/15/25. CC-A stated R27 had received sponge baths since her admission, however, she was unsure if her hair was washed. During interview on 5/21/25, at 4:54 p.m. the director of nursing (DON) stated baths were scheduled on a weekly basis. This was completed based on their designation based upon rooms. DON stated if the resident did not care for the slot, there might have been some flexibility in adjusting it, however, that was not always possible. DON stated We try to be flexible but there is (was) only so much wiggle room in that. DON stated if a bath was refused, and it was requested on another day, and the aides had time, it may occur, otherwise the next bath/shower would be completed the following week on the routinely scheduled time. Upon inquiring why a shower was not completed for R27, DON stated that if the person had a lap surgery, they would not have a shower if there were restrictions placed per the doctors orders upon admission. If there were not restricted orders, the individual could receive a shower. A request was made at this time for the specific order restricting showers for R27 from the time of her admission, however, was not provided by the DON. Upon review of R27's abbreviated discharge orders from 4/28/25, there were no orders identified for wound care to laparoscopic sites, or restrictions for showering. Upon review After Discharge Orders, from 4/28/25, the notes indicated resident had a laparoscopic procedure, however, had not restricted resident from receiving showers. A review of the information in this documentation lacked indication of this restriction. (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the standing orders, filed 5/20/25 electronically, lacked indication for shower restrictions for those with laparascopic surgical sites. The document did refer to the policy Skin and Wound Management. The document, not labeled with R27's name, was identified as being signed by the provider 2/1/25. A review of the policy, Skin Assessment and Wound Management, dated 2/25 lacked indication as to management of a laparoscopic surgical site. A review was made of resident task documentation for bathing was completed upon receipt. During the time frame of 4/28/25 through 5/7/25, there were both daily (times four) and twice daily entries (6) where the response to bathing being entered as NA, indicating not applicable. R27's documentation from 5/8/25 through 5/23, had daily entries of NA on three days, and twice daily entries of NA on 10 occasions. The documentation reflected no entries for 5/20/25, the day R27 received assistance bathing. The documentation lacked any date where resident had been assisted with bathing since her admission of 4/28/25. A follow up interview was completed with CC-A on 5/23/25, at 1:03 p.m. CC-A stated the results NA of the task documentation indicated that staff had not provided R27 with assistance to bath during the periods of 4/28/25-5/23/25 , with the exception of assistance to bathe on 5/20/25 On 5/23/25, at 1:05 p.m. the director of nursing stated the expectation of assigned tasks was that the staff would complete them as directed. The facility policy, titled Activities of Daily Living (ADL's) Maintain Ability Policy, dated 3/31/23, was reviewed. The statement of intent reads as follows: It is the policy of the facility to specify the responsibility to create and sustain an environment that humanizes and individualizes each resident's quality of life by ensuring all staff, across all shifts and departments, understand the principles of quality of life, and honor and support these principles for each resident; and that the care and services provided are person-centered, and honor and support each resident ' s preferences, choices, values and beliefs. Upon review of the procedure, the policy indicated: The facility will provide care and services for the following activities of daily living: a. Hygiene -bathing, dressing, grooming, and oral care . The policy also identified: A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming .

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to ensure the hospice plan of care had been integrated with the facility care plan for 1 of 1 resident (R35), identified to receive hospice services. Findings include: R35's admission Minimum Data Set (MDS) dated [DATE], indicated R35 had impaired cognition. R35 received assistance with activities of daily living (ADLs) including dressing, grooming, bathing, and mobility. R35's medical diagnoses included unspecified encephalopathy, cancer, atrial fibrillation (an abnormal heart rhythm which has been known to lead to complications including stroke, blood clots, and heart failure), hypertension (high blood pressure), arthritis (inflammation of joints), dementia, anxiety, depression, visual hallucinations (seeing something that is not there), adjustment disorder with anxiety, chronic pain syndrome, fibromyalgia (symptoms of widespread chronic pain, headaches, depression and other symptoms). R35's care plan printed 5/22/25, identified R35 received Hospice Cares. The care plan directed staff to maintain communication with Hospice and keep them informed of resident's condition as needed. Staff were also directed to keep Hospice informed of any changes in resident's condition. Utilize Hospice Care Standing Orders per policy. Involve Hospice care workers in care conferenc. See Hospice plan of care and visit schedule. On 5/20/25, at 3:52 p.m. R35 was observed at this time, resting on her bed, with blanket in place. Resident had an individual in room, playing guitar, and singing to resident. Resident was awake and interacting with visitor. On 5/21/25 at 5:15 p.m., a review of the Hospice file was completed. It was noted that there were calendars in place in the file to record visits of the various Hospice staff. There was only entries on the March calendar, the other calendars were blank. The calendar from March identified RN (registered nurse) visits were completed on 3/20, 3/24, and 3/27. The calendar lacked any indication of visits by others. There were no entries on the calendars labeled for April and May. Additionally, in the Hospice file, there was a document titled Hospice Aide visit log. This document had entries for 3/28, 4/4, 4/10, and 4/17. There were no further entries beyond 4/17. During interview on 5/21/25 at 5:27 p.m., the licensed practical nurse clinical coordinator (CC)-A stated the Hospice nurse was at the facility at least once or twice a week, and checked in with her when she came. CC-A stated the frequency of visits depends on the week. CC-A stated she was unaware of a calendar in the Hospice folder. CC-A stated R35 had a HHA (Home Health Aide) come out, however, was unaware of the frequency, and stated, I think once a week. CC-A stated there were other therapies which were involved, including music therapy and a Hospice social worker, however, was unaware of a schedule. if there were were questions, staff were to contact Triage for Allina Hospice, which was in the special instructions on the chart. Hospice was invited to the care conferences and did participate in the initial conference for R35. CC-A stated the Hospice care plan would be in the medical record, however, upon review of the Hospice section, CC-A confirmed only the Hospice encounter notes were present. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/21/25 5:34 p.m., the director of nursing (DON) reviewed records as identified above, as well as reviewed the medical record for the Hospice care plan. DON confirmed the Hospice care plan was not scanned into the Hospice information section and was not available for review. During interview on 5/21/25 at 5:41 p.m., licensed social worker (LSW)-A stated the social worker from Hospice was there to visit for sure every other week, if not weekly. LSW-A stated she was not notified when Hospice social worker would be coming to visit R35. LSW verified the care plan from Hospice should be filed under Hospice in miscellaneous in the electronic record. LSW-A stated Hospice was invited to care conferences, and did attend the initial care conference. Attempts on 5/22/25 to contact Hospice case manager were not successful. A review of the document Allina Health Hospice and Palliative Nursing Home Agreement Medicare/MA Respite Residential dated May 22, 2014 was completed. The document identified the facility shall coordinate with Hospice in developing a plan of care for Hospice patient. The document indicated the facility will assist with periodic review and modification of plan of care. The document directed that the facility will consult with Hospice, as reasonable necessary, with respect to any modification of the plan of care.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, interview and document review, the facility failed to provide routine assistance with range of motion (ROM) to to improve strength, mobility and improve circulation of left arm for 1 of 1 (R29) reviewed for ROM. Findings include: R29's care plan, dated 2/14/25, indicated R29 was a fall risk related to left side(d) weakness, impaired vision. The care plan directed staff to follow PT (physical therapy) and OT (occupational therapy) instructions for mobility function. The care plan additionally identified R29 had self care deficit related to left sided weakness. The care plan directed staff R29 was to receive OT as ordered by provider. Staff were also directed to follow OT instructions. A review of the Interdisciplinary Team (IDT) Conference notes was reviewed and it was noted in the document dated, 2/13/25, R29 was receiving assist with from therapy for ROM with left arm. A review of the subsequent IDT notes of 3/28/25 indicated The IDT note indicated the nurse practitioner had reviewed swelling in left forearm and ordered a compression wrap for his left arm. At the care conference, family member (FM)-B inquired of use of a sling, however, this was to be used only with transfers to encourage resident to use his left arm. The IDT care conference notes of 5/2/25, identified ongoing concerns with swelling of the left forearm and use of the compression wrap was to be continued, as well as continued use of sling only with transfers. A review of the group two (2) nursing assistant care sheet, updated 5/21/25, indicated R29 had an ROM program. A review of the task list documentation from 4/23/25-5/21/25, directed staff to provide ROM to LUE (left upper extremity): all planes (the extent or limit to which a part of the body can be moved around a joint or a fixed point) one (1) direction ten (10) times each w/ (with) extended hold *signs in room on wall to help staff. Upon review of the documentation, it was noted entries for all dates, with the exception of 4/27, 4/28, and 5/17, indicated NA (not applicable-not performed). On 4/27, 4/28, and 5/17, the notation indicated the amount of repetitions as 5 (five). On 5/19/25 at 3:15 p.m., R29 was observed to be sitting in the wheelchair. His right had was noted to resting in an open position on his lap. R29 was observed to have his left arm, with left hand in an open postion, rested on pillow resting on arm rest/lap. R29 stated he had received therapy, however, stated therapy had stopped. R29 stated staff were to perform exercises, gesturing to the multiple page documents posted to the wall with directions as to what to do, however, stated no one does this. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/22/25 at 12:14 p.m., R29 was observed to have a visitor at that time, who was observed as she provided assistance to R29 with range of motion for R29. The resident visitor (RV)-1, who identified herself as a friend, stated she assisted R29 with his exercises when she was here, and indicated she followed the directions on the wall. The visitor indicated they liked to come and make R29's day better. On 5/22/25, at 12:24 p.m., certified nursing assistant (CNA)-D stated cares performed for residents were documented on the tasks listing. CNA-D looked at this and identified R29 was to receive ROM to the left upper extremity, as indicated on the tasks section of the medical record. CNA-D stated that she had not performed this yet today, but planned to perform. On 5/22/25, at 2:35 p.m. and interview was held with CNA-B and CNA-C. CNA-B stated it was rare to complete ROM in general. CNA's B and C both stated the most important tasks were completed, which included feeding assists and showers, however, ROM was infrequently done for the residents assigned. On 5/23/25 at 1:03 p.m., licensed practical nurse (LPN)/clinical coordinator (CC)-A indicated upon review of the task listing for R29, completion of ROM was lacking for all days with the exceptions of 4/27, 4/28, and 5/17. CC-A stated the documentation indicated staff were not completing ROM. CC-A stated it was her expectation that staff should have been completing ROM. CC-A verified the care sheet directed staff to perform the ROM program. CC-A stated she was unaware the ROM was not consistently completed. On 5/23/25, at 1:05 p.m. the director of nursing stated she had reviewed the information as documented on the tasks sheet and identified it had not been done often. DON stated it was her expectation that ROM was completed as directed, on a daily basis as outlined. A facility policy, Activities of Daily Living (ADLs)/Maintain Abilities Policy, dated 3/31/23, identified the intent as being: It is the policy of the facility to specify the responsibility to create and sustain an environment that humanizes and individualizes each resident ' s quality of life by ensuring all staff, across all shifts and departments, understand the principles of quality of life, and honor and support these principles for each resident; and that the care and services provided are person-centered, and honor and support each resident ' s preferences, choices, values and beliefs. Within the policy, it was identified under the procedure the following: 1. Based on the comprehensive assessment of a resident and consistent with the resident ' s needs and choices, the facility will provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. 2. The facility will ensure a resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living. The facility policy lacked specific identification as to process/policy for performance of ROM, however, when asked for a more specific policy, the facility stated ROM was addressed within the ADL's policy.

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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. Based on observation, interview and document review, the facility failed to assess and analyze a fall with significant injury for 1 of 2 residents (R11) reviewed for falls. Findings include: R11's minimum data set (MDS) completed for significant change dated 3/5/25, was noted to be cognitively intact and able to communicate her thoughts, needs, and wishes. R11 was identified as using a walker and wheelchair for mobility. R11 received assistance to complete her activities of daily living (ADLS), however, actively participated with cares. R11's medical diagnosis included anemia (low levels of healthy red blood cells or hemoglobin), coronary artery disease (a build up in the walls of the blood vessels which supply blood to the heart), hypertension (high blood pressure), diabetes (a group of diseases which affects how the body uses blood sugar), difficulty in walking/unsteadiness on her feet, muscle weakness, peripheral autonomic neuropathy (nerve damage which affects the system which controls involuntary body functions such blood pressure and heart rate, and weakness. The MDS identified R11 had a history of falls with no injury since the last assessment period. R11's Care Areas Assessment, dated 3/5/25, indicated areas to focus on for specialized care included activities of daily living (ADLs-including transfers and mobility), falls, pressure ulcers, pain and use of psychotropic (use of medication affect mood state and behavior) medication. R11's care plan, date of print 5/21/25, identified R11 was a fall risk related to: decreased mobility, psychotropic meds, intermittent confusion, and history of fall. Staff were directed to ensure wheelchair breaks were locked and wheelchair remained close to resident when transferring. R11 was identified as being impulsive at times. Staff were directed to remind R11 to slow down when transferring. This problem statement was identified as being initiated on 4/16/21. The care plan directed staff to monitor and document on safety, as well as review information on past falls and attempt to determine cause of falls. Staff were directed to record possible root causes, and were also directed to remove any potential causes if possible. The care plan directed staff to educate resident/family/caregivers/IDT(interdisciplinary team) as to causes. On 5/19/25 at 5:32 p.m., during interview R11 was seated in wheelchair and was propelling herself into her room. R11 stated everything was going well and reported no concerns to surveyor. On 5/21/25 at 12:49 p.m., R11 was observed walking in the hallway in gripper socks using a rolling walker. R11 was walking with occupational therapist (OT)-A who was bringing wheelchair up behind R11. R11 was observed to have abruptly stopped and sat down in wheelchair. OT-A instructed R11 of need to verbalize need/desire to sit down. OT-A did not have the wheelchair brakes on. OT was able to safely assist R11 to a seated position. During record review on 5/19/25 at 7:53 p.m., a progress note, written on 4/30/25 at 2:07 p.m., identified: Resident was sent to hospital after a fall accident with therapy. Res had a cut under left eye and hit on head. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A subsequent note from 4/30/25 at 6:43 p.m., identified the head/brain/facial bones and cervical spine were assessed with computerized tomography (CT-an imaging test which helps healthcare providers detect injuries). This was completed related to R11 having experienced a fall with facial injuries. The findings included the following: Head CT: Intracranial contents: No intracranial hemorrhage (bleeding into the brain), extraaxial collection(collections of fluid within the skull, but outside the brain), or mass effect (a space occupying lesion which may increase intracranial pressure, and displace soft tissues of the brain). No CT evidence of acute infarct (tissue death). Chronic lacunar infarcts in the right basal ganglia (small deep infarcts primarily caused by chronic hypertension, atherosclerosis, and diabetes). Mild presumed chronic small vessel ischemic changes (changes related to decrease blood flow). Mild generalized volume loss. No hydrocephalus (build up of fluid in the brain). Head CT: No acute intracranial findings(no hemorrhage, shift, or mass effect). Mild generalized cerebral volume loss and presumed chronic microvascular ischemic changes of the white matter. A review of the narrative notes lacked indication of a fall analysis was completed. The initial entry did identify the fall occurred with therapy, however, it lacked further information related to the incident to attempt to determine the root cause or possible interventions to prevent this from recurring in the future. On 5/20/25 at 2:55 p.m., an interview was completed with licensed practical nurse (LPN)/clinical coordinator (CC)-A. Upon review of the electronic record, CC confirmed there were no forms on file to indicate a review of the fall had been completed. CC-A indicated the process was to have included a risk management report. The presence of a risk management report would have triggered her to have completed an Incident Review and Analysis Document. CC-A stated this should have been completed to look at the potential root cause was for the fall, and to place interventions to decrease the potential for having this occur again. On 5/22/25 at 11:57 a.m., the director of nursing (DON) stated upon review of the medical record, there were areas to document on the medication administration record (MAR) to prompt assessment of resident following the fall, however, there was no formalized fall analysis. The DON stated a risk management report should have been completed. DON stated from the risk management report, the CC would complete an Incident Review and Analysis document. This information provided details of the fall to allow for analysis of the incident to look for root cause, and identify potential interventions to be implemented to prevent future falls. DON stated this documentation should have been completed at the time of the incident. The facility policy, Fall Prevention and Management, dated 2/2024 identified the purpose of this protocol is to identify residents at risk for falls, implement fall prevention interventions, provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall. The policy identified a Fall Risk Evaluation was completed to identify and document the resident ' s risk factors for falls upon admission, annually, with a significant changed in condition, and as needed. The policy identified after the initial actions after the fall, and stabilization of the resident has been completed, nursing staff will complete an incident review and analysis. The policy identified the staff were to clarify the details of the fall, such as when the fall occurred, where it occurred and what the individual was trying to do at the time the fall occurred. The policy directed nursing staff to try to identify possible or likely causes of the incident. This would refer to resident-specific evidence including medical history, known functional impairments, etc. Staff will monitor and document the resident ' s response to and the effectiveness of interventions put in place to prevent further falls for 72 hours post fall.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure adequate monitoring for tardive dyskinesia (TD- a disorder that sometimes develops as a side effect of long-term treatment with neuroleptic (antipsychotic) medications) was implemented for 1 of 5 residents (R35) reviewed for unnecessary medications. Findings include: R35's admission Minimum Data Set (MDS) dated [DATE], indicated R35 had impaired cognition. R35 was noted to receive assist with activities of daily living (ADLs) including dressing, grooming, bathing, and mobility. R35's medical diagnoses included unspecified encephalopathy (brain disease, damage, or malfunction which encompasses a range of conditions that could cause brain dysfunction, which might manifest as confusion, memory loss, personality changes, or severe symptoms like coma), cancer, atrial fibrillation (an abnormal heart rhythm which has been known to lead to complications including stroke, blood clots, and heart failure), hypertension (high blood pressure), dementia, anxiety, depression, visual hallucinations (seeing something that is not there), adjustment disorder with anxiety, chronic pain syndrome, and fibromyalgia (symptoms of widespread chronic pain, headaches, depression and other symptoms). R35's care plan printed 5/22/25, indicated R35 had alteration in cognition related to confusion, disorientation to place and time. Poor insight to her deficits or cognitive loss. Poor historian. Sundowning type behaviors of crying and calling out. Has decreased in intensity since admission. R35's diagnoses included major neurocognitive disorder, with behavioral disturbance, encephalopathy due to medical illness (various infections), visual hallucinations, and low vision due to retinal pigmentation disease. The care plan directed staff to follow recommendations from mental health provider. The care plan lacked indication of baseline monitoring for side effects of antipsychotic medication. R35's Medication Administration Record (MAR), printed 5/20/25, indicated R35 received the following medications: - Risperidone 1 milligram (mg) by mouth at bedtime for agitation/delirium. Start date of 5/5/25. Risperidone is a medication classified as an antipsychotic medication. This is a medication that works by changing certain signals in your brain which affect how you feel and act. - Risperidone 0.5 mg by mouth two times a day for delirium/ agitation. Start date 5/5/25. A review of R35's medical record lacked indication that an Abnormal Involuntary Movement Scale (AIMS) evaluation had been completed. AIMS evaluation was a test developed to measure involuntary movements known as tardive dyskinesia (TD). A request was made for the documentation of AIMS testing for R35, and it was noted by the facility there was no AIMS on resident record, per documentation on the form titled Request for Documentation for Unnecessary Medications. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/20/25 at 3:52 p.m., R35 was observed in her room, resting on her bed, with blanket in place. R35 had a visitor in her room, playing her guitar, and singing to resident. Resident was observed to be awake, and was interacting with her visitor. During interview on 5/22/25 at 1:46 p.m., the director of nursing (DON) stated the AIMS evaluation was important to assess if the residents had specific side effects of TD. DON stated this was to be done at the time of admission and every six months for residents receiving antipsychotic medications. DON stated this was last done on 5/20/25, however, had not been completed until after information had been requested by surveyors. The facility policy, titled Psychotropic Medication Use Policy, created 4/25, identified the facility that DISCUS (Dyskinesia Identification System Condensed User Scale) or AIMS testing will be completed at baseline, semi-annually and monthly times 3 upon discontinuation for antipsychotic medications.

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

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and document review, the facility failed to ensure medications had both open dates and expiration dates marked on the medications so staff new how long the medications were good for. This had the ability to affect all residents on the transitional care unit (TCU) who received medications. Findings include: On 5/21/25 at 12:21 p.m., a review of the TCU medication care and treatment cart was performed. Three different insulin dial up pens were observed without open dates or expiration dates documented on the pens. Three different inhalers were also observed without open dates or expiration dates. During an interview on 5/21/25 at 12:36 p.m., licensed practical nurse (LPN)-A reviewed the medications and confirmed there were no open dates or expiration dates on the medications. LPN-A could not report when the medications were opened or how long they were good for once the medications were opened. LPN-A did not know how long insulins or inhalers were good for after opened and stated, I need to check with my supervisor. On 5/22/25 attempts to contact the pharmacy consultant were not successful. During an interview on 5/22/25 at 12:27 p.m., the director of nursing (DON) stated an expectation that medication would be dated with both the open date and expiration date, so staff were aware how long they were good to administer. Administering medication beyond the expiration date could result in the resident responding differently to the medication as the potency may change. A facility policy on dating and disposal of multi-use medication was requested, however, none was provided

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to ensure food served to the residents was palatable, at a pleasing temperature, and in a timely manner for 4 of 4 residents R145, R29, R33, and R93 reviewed for food concerns. Findings include: R145's admission Minimum Data Set (MDS) dated [DATE], indicated R145 was cognitively intact. R145 was independent with all aspects of eating and was independent with mobility. R145's medical diagnoses included gastroesophageal reflux disease (GERD-acid indigestion) and diabetes (a disease which impacts the body's ability to process sugar in the blood). On 5/19/25 at 2:22 p.m., R145 stated the food was never warm. R145 went on to state she would love a hot meal. R145 stated the coffee was cold and the food was inconsistent. R145 did not indicate she had requested an alternate meal/new plate, or fresh coffee. R29's admission MDS dated [DATE], indicated R29 experienced moderate cognitive impairment. The assessment indicated R29 was independent with eating. R29's medical diagnoses included sequalae of cerebral infarction (details of cerebral infarction (stroke-and its effects it can cause to the brain including, but not limited to, change in mobility, loss of movement of one side of the body, vision problems, memory loss and difficulty with problem solving, emotional and behavioral changes, and seizures), heart failure (a condition where the heart is not able to pump enough blood for the body's needs for blood and oxygen), hypertension (high blood pressure), diabetes (a group of diseases which affects how the body uses blood sugar), and muscle weakness. On 5/19/25 at 3:36 p.m., R29 stated today the tray (at noon) was late. R29 stated there should be alternates for food. Today, there were no alternates ready for pork. R29 stated the culinary director went to make something as an alternate and provided chickens strips. R29 went on to state the food is late all the time. R33's admission MDS, completed on 3/3/25, indicated R33 had moderate cognitive impairment. R33 was independent with eating. R33's medical diagnoses included hyponatremia (low sodium (salt), a non-cancerous brain tumor, myocardial infarction (heart attack), generalized weakness, and unsteadiness. On 5/19/25 at 5:30 p.m., R33 stated the food is so-so. R33 commented the alternates available are the same things all the time. The food is not consistently hot, and described the food received with meal trays as pretty much warm. R33 stated she had not requested staff to warm up the meal tray if received at less than desired temperature. On 5/19/25 at 11:25 a.m., the culinary director (CD) stated mealtimes at the facility were at 8:00 a.m., 12:00 p.m., and 5:00 p.m. On 5/19/25 at 12:13 p.m., observation was completed in the dining room. Meal service was to begin at 12:00 p.m. At this time, beverages were being served by dietary aide (DA)-A, however, the noon meal had not begun being served. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/19/25 at 12:14 p.m., temperature logs were received from 5/16/25 to the present time on 5/19/25 at 12:14 p.m. The culinary services cook (CSC)-A stated she had temped the foods earlier yet had not recorded them. The temperature log reflected no temperatures had been entered for 5/16/24-5/19/25. Upon review of the temperature logs, it was noted from 5/1/25 -5/15/25, there were 11 meals out of 45 where temperatures were not recorded. On 5/19/25 at 12:25 p.m., the first meal was served, 25 minutes after the start of the designated mealtime. Upon initiation of meal service, it was identified there were no alternatives to the pork cutlet served. It was also identified that an alternate meat would need to be prepared as there were three residents who did not consume pork products. CD proceeded to the kitchen to prepare an alternate protein. On 5/20/25 at 12:01 p.m., meal service observation was initiated at this time in the dining room. DA-A was serving beverages to those residents present. At 12:17 p.m., the steam table arrived in the serving kitchen. At 12:24 p.m., it was noted the first meals were served to three residents. At 12:30 p.m., all residents have been served in the dining room. On 5/20/25 at 12:47 p.m., R93 stated it was a small lunch. Quality and quantity is always small. Timing is (was) always a thing. R93 stated he had enough to eat however, expressed concerns regarding the quality. R93 stated there was often an extended wait for meals. On 5/20/25 at 3:20 p.m., an interview was completed with the Regional Culinary Director (RCD), and Registered Dietitian (RD). RCD stated checking of the temperature of foods, should occur right before the meal was serve, and should be completed with every meal. RCD stated she was surprised there were concerns regarding foods as they used heating pellets to keep the plates warm, heated plates, and domed covers. RCD stated there may be some concerns regarding delivery once food was sent out for tray service. RCD stated if the food was reported to be not up to temperature, the food would be either reheated or the resident would be served a new plate. RCD stated she had heard mealtimes have been delayed at times. RCD and RD stated there were routine Food Council meetings to review resident concerns, and stated these meetings were often held on the same day as Resident Council. A request was made for Food Council meeting minutes; however, none were received. A facility policy, titled Meal Times, review 9/2012, identified it was the policy of the facility to serve meals to meet the standards of the surveying agencies, specifying no more than 14 hours between the evening meal of one day and the breakfast meal of the next day. Although the policy included a section which indicated Meal times will be: there lacked indicated times for breakfast, noon, and evening. The policy indicated the Hospitality Services Manager was responsible to monitor the system to assure adherence. The policy went on to state all staff were responsible for following this schedule. A facility policy titled Food and Nutrition Services, revised October of 2017, identified Each resident was provided with a nourishing, palatable, well-balanced diet that met his/her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. The policy identified the meals and/or nutritional supplements would be served within 45 minutes of either resident request or scheduled meal time. The policy also identified Meal times are posted in the facility common areas. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A facility policy titled Food Preparation and Service, revised April of 2019, identified proper hot and cold temperatures were maintained during food service. It also identified the temperature of foods held in steam tables were monitored throughout the meal by food and nutrition services staff.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and document review, the facility failed to consistently date fresh and frozen items at the time they were opened, or placed in a container, and failed to remove items which were beyond the acceptable date of use from the refrigerator. The facility also failed to consistently verify the temperatures of freezers were within the desired range to assure food integrity and follow through on the temperatures outside of the desired range. The staff also failed to consistently implement the use of hair nets and beard restraints while preparing and serving food. In addition, food temperature monitoring lacked consistency of completion following food preparation and prior to serving. This had the potential to affect all 32 current residents, as well as staff and visitors who ate the food from the kitchen. Findings include: Food storage: On 5/19/25 at 11:31 a.m., the culinary director (CD) reviewed the products of the refrigerator at this time. The CD stated food items should be used within seven days of placing in the refrigerator. The following items were noted to be in the refrigerator and outside of the stated parameters: A five-pound box of bacon, with half of the box remaining was observed to be in an opened paper box which was not sealed. This was removed by the CD. A bottle of lemon juice which was noted to be 32 ounces, with half of a bottle remaining. The manufacturer expiration date was noted to be 3/25. The bottle had been dated on 3/24 as being opened. A stack of sliced cheese, approximately one and a half inches in height, was wrapped in plastic wrap, and was dated 5/8/25. The wrapping was not secured, and one corner of the cheese was opened with cheese crumbling off. The package of cheese was free from mold. The CD removed the cheese from the refrigerator to be repackaged. A one pound package of butter, was observed to be partially unwrapped, and noted to have approximately half of the block remaining. This was undated. This removed from the refrigerator and disposed of. A six quart container was observed to be in the refrigerator with two quarts of black olives remaining. This was noted to be dated 5/1/25. This was removed from the refrigerator and disposed of. An open package of ham, containing six slices of ham was observed to be dated 5/6/25. This was removed from the refrigerator and disposed of. A one-pound package of bologna, white in color, with watery substance observed at the bottom of the packaging was noted to be dated 3/31/25. This was disposed of. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A bag of precooked sausage, dated 5/8/25, was observed to be in the refrigerator. CD stated they had just placed this in the refrigerator on Friday, 5/16/25, however, acknowledged staff would be unaware of the date of 5/8/25 being the date received on delivery and not the date the bag was placed in the refrigerator. CD stated precooked foods could be stored seven days. A sandwich size baggy of chopped up onions was observed in the refrigerator, dated 5/7/25. There was a watery substance at the bottom of the bag, and the onions were soft to touch. This bag was removed and disposed of. On the upper shelf of the refrigerator, there was an undated plastic cup, approximately two ounces in size, of sour cream. This item was removed and disposed of. The dry storage room was surveyed and it was noted to have two onions which had two inches of green sprouts out of the top of them. The onions were noted by the CD to be soft and spoiled and were disposed of. A review of the food items in the freezer was completed and the following was identified. Within the freezer, there was noted to be two chunks of ham in a plastic bag, dated 5/14/25, which CD noted to weigh approximately one and a half pounds which had a large amount of ice crystals surrounding the chunk of ham and laying in the bottom of the bag. A second bag of ham was also noted to be in a plastic bag, covered with many crystals, both on the ham and in the bottom of the bag. This bag was measured at three pounds. CD stated she was unsure if the ham was not cooled down properly to cause formation of ice crystals. Both bags of ham were removed and disposed of. A four-pound bag of fully ice encrusted fajita blend vegetables was observed. This contained a pepper and onion mix. This was not opened and undated. This was removed and disposed of. A review of other frozen vegetables was completed with no other vegetables noted to be encased with ice. A bag of chili sauce was found thawed in freezer, with a date of being opened as 5/13/25, however, was not frozen. The bag was noted to weigh was almost three pounds. CD was unsure why this would have been dated 5/13/25, and yet be thawed to touch. On 5/20/25 at 3:20 p.m.,Regional Culinary Director (RCD) stated foods are dated upon arrival/receipt. RCD stated food products should then be dated with date opened. RCD stated if the food product was a cooked product, it was to be used within three days. RCD stated if it was cheese, it was to be discarded after seven days. Ham was to be disposed of within seven days. A facility policy, Food Receiving and Storage, revised October 2017, identified foods were to be received and stored in a manner that complied with safe food handling practices. The policy indicated all foods stored in the refrigerator or freezer were to be covered, labeled, and dated (use by date). Although the policy identified to products were to be dated, it lacked definition as to what the time frames were for the food products to be used by, with the exception being that beverages must be dated when opened and discarded after twenty four hours. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A policy titled Refrigerators and Freezers, undated, indicated the facility will ensure safe refrigerator and freezer maintenance, temperature and sanitation, and will observe food expiration guidelines. The policy stated all food shall be appropriately dated to ensure proper rotation by expiration dates. Received dates (dates of deliver) will be marked on cases and on individual items removed from cases for storage. Use by dates will be completed with expiration dates on all prepared foods in the refrigerators. Expiration dates on unopened food will be observed and use by dates indicated once food is opened. All expired items were to be discarded. Although the policy addresses the use by date, the policy lacks specifications to what the parameters are to be used for determining the use by date. Monitoring of freezer temperatures: On 5/19/25 at 12:04 p.m., a review was completed of the freezer temperature log for freezer A. The log indicated the temperature was to be less than zero degrees, if temperature was higher than zero the staff were directed to contact the culinary manager ASAP (as soon as possible). Upon review of the log, it was noted the temperature was identified as being greater than zero degrees Fahrenheit on four occasions: on 5/12/25, the temperature was recorded as 2.6, on 5/13/25, the temperature was recorded as 2, on 5/14/25, the temperature was recorded as 13.5 degrees Fahrenheit. The log was noted to lack temperature monitoring in the afternoon on four dates (5/14/25, 5/15/25, 5/16/25, 5/18/25) CD stated she was unaware of the freezer temperature being greater than zero degrees. CD stated when the temperature was greater than zero degrees, the staff were to report this to the CD and follow up was to be initiated with maintenance. On 5/20/25 at 3:31 p.m., RCD stated the freezer at the time the temperature was out of range on the freezer, it may have been going under a defrost. RCD stated the temperature was to be monitored on the inside of the freezer. RCD stated she had reviewed the log. RCD stated when irregularity was noted, staff were to allow the freezer to cycle through and go back and recheck the temperature. RCD stated if the abnormality persisted, the CD was to follow up with maintenance, or other departments as indicated. A policy titled Refrigerators and Freezers, undated, indicated the facility will ensure safe refrigerator and freezer maintenance, temperature and sanitation, and will observe food expiration guidelines. The policy outlined that the temperatures of the freezer was to have been less than zero degrees Fahrenheit. The policy directed the supervisor to take immediate action if temperatures were out of range. Actions needed to correct the temperatures were to be recorded on the tracking sheet, including the repair personnel and/or department contacted. Hair nets and beard restraints: On 5/19/25 at 12:18 p.m., CD was observed to wearing a hair net; however, the sides of her hair were not completely contained within the hair net. CD was observed with hair net not partially covering her hair in the kitchen, and in the serving kitchen. On 5/20/25 at 12:26 p.m., RCD was observed in the serving kitchen. Although RCD was observed to have a hair net in place, it lacked coverage of her bangs, which were noted to be uncovered on her forehead. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 5/20/25 at 3:43 p.m., registered dietitian (RD) stated hair nets were to be worn in the kitchen, and outside of the kitchen when serving food. RD stated hair nets were to be worn so it covered all of the person's hair. Hair was to be tucked in, no matter what part of your hair it was. On 5/20/25 at 3:47 p.m., RDC acknowledged her bangs were not covered up by her hairnet and stated I know better. On 5/20/25 at 5:13 p.m., dietary assistant (DA)-B, was observed placing tablecloths on serving tables in the dining room. DA-B's hair was observed to be braided and pulled back away from her face, however, there were areas around forehead and ears where the hair net was not restraining/containing the hair. Upon interview, DA-B stated she was unaware her hair was outside of the hair net, and stated it was important for hair nets to be used so that the hair would not get into the food. On 5/21/25 at 4:45 p.m., DA-C was observed in the dining room setting up tables for the evening meal. DA-C was observed to have a hair net in place to cover his head, however, DA-C was also observed to have facial hair present with a light mustache and beard. DA-C was not wearing any facial hair restraint at this time. On 5/21/25 at 4:55 p.m., RDC was observed walking by at the time DA-C was preparing the dining room. Surveyor inquired of RDC if DA-C typically used a facial hair restraint? RDC stated, He typically does, for sure. 5/21/25 at 4:59 p.m., RDC approached surveyor and stated she had followed up on use of beard nets at the facility. RDC stated the facility lacked beard nets in house. RDC stated in the interim, DA-C would cover face with a face mask. A facility policy, Food Preparation and Service, revised April of 2019, identified under Food Service/Distribution that Food and nutrition services staff (were to) wear hair restraints (hair net, hat, beard, restraint, et.) so hair does not contact food. Temperature monitoring of meals served: On 5/19/25 at 12:14 p.m., temperature logs were received from 5/16/25 to the present time on 5/19/25 at 12:14 p.m. The culinary services cook (CSC)-A stated she had temped the foods earlier yet had not recorded them. The temperature log reflected no temperatures had been entered for 5/16/24-5/19/25. Additional logs were requested from the CD from the start of the month. Upon review of the temperature logs, it was noted from 5/1/25 -5/15/25, there were 11 meals out of 45 where temperatures were not recorded. CD stated the temperatures were to be checked prior to serving the meals, and indicated the temperatures were to be logged immediately after they are checked. On 5/20/25 at 3:32 p.m., RCD stated staff were to check the temperature of foods right before the meal was served. RCD stated there were interventions to maintain food temperatures which included heating pellets, heating plates, domed plates. If the food was not maintaining the desired temperature, her concern would be related to the delivery process, function of the steam table being on, and equipment being efficiently used. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A facility policy titled Food Preparation and Service, revised April of 2019, identified under Food Preparation, Cooking and Holding Time/Temperatures that food thermometers used to check food temperatures were clean, sanitized, and calibrated for accuracy. The policy identified under Food Service and Distribution, that the proper hot and cold temperatures were maintained during food service. The policy indicated the temperature of foods held in steam tables were monitored throughout the meal by food and nutrition services staff. The policy lacked definition as to when the temperatures were to be initially taken prior to meals, and the parameters when the temperatures are to be rechecked.

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F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 seven residents (R144, R92, R27, R5, R192, R21, and R2) who currently resided in these rooms. Findings include: During the entrance conference on 5/19/25 at 11:34 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. The following double resident rooms did not meet the required minimum square footage per resident: room [ROOM NUMBER] = 150 square feet, or 75 square feet per resident (empty). room [ROOM NUMBER] = 152.5 square feet, or 76.25 square feet per resident (R144). room [ROOM NUMBER] = 150 square feet or 75 square feet per resident (R92). room [ROOM NUMBER] = 150 square feet or 75 square feet per resident (empty). room [ROOM NUMBER] = 150 square feet or 75 square feet per resident (R27). room [ROOM NUMBER] = 150 square feet or 75 square feet per resident (R5). room [ROOM NUMBER] = 150 square feet or 75 square feet per resident (R192, R21). room [ROOM NUMBER] = 150 square feet or 75 square feet per resident (R2). Interview on 5/22/25 at 8:35 a.m., R92 stated she did not have a roommate at that time, but she had roommates before. Resident stated the size of the room was not an issue. She did not believe past roommates had complaints about the room size or functionality either. Interview on 5/22/25 at 8:53 a.m., Administrator confirmed one of the waivered rooms had two residents in it. Administrator stated the facility planned to keep these rooms available for double occupancy if needed based on census. Administrator provided list of rooms with waivers dated 4/28/25, it included room numbers, measurements, and square footage of each of the eight rooms.