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	07/02/2026

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 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 ensure a resident's dignity was maintained when a nephrostomy drainage bag (collection pouch that gathers urine directly from a tube surgically placed in the kidney) was left uncovered and visible from the hallway for 1 of 1 resident (R5) reviewed for dignity.Findings include:R5's quarterly Minimum Data Set (MDS), dated [DATE], identified R5 had moderate cognitive impairment, required assistance with activities of daily living (ADLs), and diagnoses included multiple sclerosis (a disease affecting the brain and spinal cord causing weakness and decreased physical function), and neurogenic bladder (loss of bladder control due to a nerve problem). The MDS further identified R5 had an indwelling catheter.R5's care plan, dated 6/1/26, identified R5 was incontinent of bowel and bladder related to multiple sclerosis and decreased mobility. The care plan identified R5 had a left nephrostomy tube due to kidney stones and a Foley catheter. The care plan directed staff to provide incontinence care, monitor for signs and symptoms of a UTI, empty the left nephrostomy as ordered, and ensure R5 was appropriately covered and dignity was provided.During an observation on 7/1/26 at 12:42 p.m., R5 was seated in a Broda wheelchair in his room with the door open to the hallway. R5's nephrostomy drainage bag was hanging uncovered from the left armrest of the chair. The uncovered nephrostomy drainage bag was visible from the hallway to anyone who walked by R5's room.During an observation and interview on 7/1/26 at 12:47 p.m., trained medication aide (TMA)-A entered R5's room with R5's meal tray. TMA-A stated the nephrostomy drainage bag was usually hung on the armrest of R5's wheelchair.During an interview on 7/1/26 at 1:08 p.m., the registered nurse case manager (RNCM) and director of nursing (DON) confirmed R5's nephrostomy drainage bag was not covered and was visible from the hallway. The RNCM and DON stated the nephrostomy drainage bag should have been covered because the uncovered bag was a dignity concern.The facility's Combined Federal and State [NAME] of Rights policy, dated 11/28/16, identified residents had the right to a dignified existence. The policy indicated the facility must treat each resident with respect and dignity and provide care in a manner and environment that promoted maintenance or enhancement of the resident's quality of life, recognized each resident's individuality, and protected and promoted resident rights.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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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 maintain resident equipment in a clean and sanitary manner for 1 of 1 resident (R14) reviewed for a safe, clean, comfortable, and homelike environment.Findings include:R14's quarterly Minimum Data Set (MDS), dated [DATE], identified R14 had severe cognitive impairment, required assistance with activities of daily living (ADLs), and diagnoses included stroke, hemiplegia, and dementia. During an observation on 6/29/26 at 1:23 p.m., R14's wheelchair was visibly soiled and the wheelchair frame had an accumulation of dirt and debris. The back of the wheelchair, behind the seat, had a buildup of dirt and debris. The wheelchair seat had a brown substance adhered to the edge of the seat, and food remnants were observed on the seat.During an observation on 6/30/26 at 9:33 a.m., R14 was lying in bed, and R14's wheelchair remained visibly soiled with previously identified dirt and debris.During an observation on 6/30/26 at 4:51 p.m., R14 was lying in bed, and R14's wheelchair remained visibly soiled with accumulated dirt and debris.During an observation on 7/1/26 at 9:33 a.m., R14 was seated in the wheelchair in R14's room. R14's wheelchair remained visibly soiled with accumulated dirt and debris.During an observation on 7/2/26 at 8:24 a.m., R14 was seated in the wheelchair in R14's room. R14's wheelchair remained visibly soiled with accumulated dirt and debris.During an interview on 7/2/26 at 12:08 p.m., nursing assistant (NA)-A stated night shift staff were responsible for cleaning resident wheelchairs when the wheelchairs were identified as dirty.During an interview on 7/2/26 at 1:24 p.m., the registered nurse case manager (RNCM) and director of nursing (DON) confirmed R14's wheelchair was visibly soiled with debris present on the wheelchair frame and seat. RNCM and DON stated the condition of the wheelchair was a concern and created an infection control concern. RNCM and DON stated nursing assistants were responsible for cleaning resident wheelchairs. RNCM and DON further stated wheelchairs should have been cleaned by night shift when residents were out of the chairs, and cleaned weekly during residents' scheduled showers.The facility's Wheelchair Cleaning Policy, undated, identified the purpose of the policy was to maintain a clean, safe, and homelike environment by ensuring wheelchairs were cleaned regularly. The policy directed staff to clean wheelchairs with mild detergent and water prior to disinfecting when wheelchairs were visibly soiled. The policy further directed staff to clean and disinfect all areas, including push handles, seat and backrest, armrests, footrests, leg rests, seat belts/straps, hand rims, brakes, wheelchair frames, cushions, and all high-touch surfaces. The policy indicated deep cleaning of wheelchairs was to be completed by night shift on residents' bath days and identified all staff were responsible for cleaning and disinfecting wheelchairs immediately when visibly soiled.

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure a psychotropic medication prescribed on an as-needed (PRN) basis was limited to 14 days, or had documentation from the prescribing practitioner with a rationale for continued use beyond 14 days, for 1 of 5 residents (R19) reviewed for unnecessary medications.Findings include:R19's significant change in status Minimum Data Set (MDS), dated [DATE], identified R19 had moderately impaired cognition and diagnoses included depression and chronic pain. The MDS further identified R19 received antianxiety and opioid (pain medication) medications.R19's care plan, dated 6/26/26, identified R19 was at risk for psychotropic medication adverse drug reactions (ADRs) related to the use of psychotropic medications and/or other medications used to treat a psychotropic indication. The care plan goal indicated R19 would not experience ADRs related to the current psychotropic medication regimen. Interventions directed staff to administer medications as ordered, monitor target behaviors and ADRs, report suspected ADRs to the medical provider, ensure medications were reviewed by the medical provider and pharmacist, and update the medical provider regarding medication effectiveness and/or ADRs as needed.R19's physician orders, dated 6/29/26, included an order initiated on 5/21/26 for lorazepam solutab (an antianxiety psychotropic medication) 0.5 milligrams (mg) by mouth every four hours as needed (PRN) for anxiety/restlessness. The order lacked a stop date and allowed the PRN psychotropic medication to remain available for use beyond 14 days. However, R19's electronic health record (EHR) lacked documentation the prescribing practitioner documented a clinical rationale for continued use of PRN lorazepam beyond 14 days.During an interview on 7/2/26 at 1:24 p.m., the registered nurse case manager (RNCM) and Director of Nursing (DON) reviewed R19's medical record and confirmed R19's PRN lorazepam order lacked a 14-day stop date. The RNCM and DON stated PRN psychotropic medications required a 14-day stop date unless the resident was receiving hospice services and the provider specified the duration. The RNCM stated the order should have been clarified with the provider. The RNCM and DON stated monitoring PRN psychotropic medications was important due to the potential for adverse side effects, and PRN use should not be prolonged without review. The RNCM and DON stated staff needed to monitor medication use, communicate with the provider, and evaluate if medication changes were needed based on the resident's continued use.A facility policy related to psychotropic medication use and PRN psychotropic medication duration requirements was requested; however, the facility did not provide a policy prior to the end of the survey.

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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 grooming assistance according to a resident's assessed needs and preferences for 1 of 1 resident (R8) reviewed for activities of daily living (ADL) care.Findings include:R8's quarterly Minimum Data Set (MDS), dated [DATE], identified R8 had severe cognitive impairment, required staff assistance with activities of daily living (ADLs), and diagnoses included stroke, dementia, and hemiplegia (weakness or paralysis affecting one side of the body).R8's care plan, printed 6/30/26, identified R8 had a self-care deficit related to weakness and dementia. The care plan identified R8 had a history of being combative with cares, yelled out instead of using the call light, and would be dressed, groomed, and bathed according to his preferences. Interventions directed staff to re-approach R8 if cares or treatments were refused, respect R8's choices, and document refusals. The care plan further identified R8 required assistance of one staff member with grooming and identified R8's shaving preference was to be shaved daily.A Vulnerable Adult Maltreatment Report, dated 12/8/25, identified family member (FM)-A reported R8's beard trimming had not occurred.During observation on 6/30/26 at 4:05 p.m., R8 was lying in bed with a full beard of approximately one to two inches in length.During observation on 7/1/26 at 12:21 p.m., R8 was seated at a table while a nursing assistant (NA) assisted R8 with eating. R8 continued to have a full beard of approximately one to two inches in length.During an interview on 7/2/26 at 12:08 p.m., NA-A stated staff should offer shaving assistance and notify the nurse if a resident refused. NA-A stated R8's beard was normal for him, staff did not shave him, and stated, I think he likes to have a beard. NA-A was unable to provide evidence R8 refused shaving assistance.During an interview on 7/2/26 at 1:24 p.m., the registered nurse case manager (RNCM) and Director of Nursing (DON) stated R8's beard had been present for a while. The RNCM and DON stated they expected staff to offer shaving assistance, and if R8 refused, the refusal should have been documented. The RNCM and DON reviewed R8's medical record and confirmed there was no specific task established for shaving, and acknowledged R8's care plan identified his preference was to be shaved daily.The facility's Activities of Daily Living (ADLs)/Maintain Abilities Policy, updated 3/31/23, identified the facility would create and sustain an environment that individualized each resident's quality of life by ensuring care and services were person-centered and honored each resident's preferences, choices, values, and beliefs. The policy indicated, based on the comprehensive assessment and consistent with the resident's needs and choices, the facility would provide necessary care and services. The policy further indicated residents who were unable to carry out activities of daily living would receive necessary services to maintain grooming and personal hygiene.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure a nephrostomy drainage system was positioned to allow unobstructed dependent drainage of urine for 1 of 1 resident (R5) reviewed for indwelling catheter care.Findings include:R5's quarterly Minimum Data Set (MDS), dated [DATE], identified R5 had moderately impaired cognition, required assistance with activities of daily living (ADLs), and diagnoses included multiple sclerosis and neurogenic bladder (lack of bladder control due to nerve problems), and septicemia (severe infection in the bloodstream). The MDS further identified R5 had an indwelling urinary catheter.R5's care plan, printed 7/1/26, identified R5 had an alteration in elimination and was incontinent of bowel and bladder related to multiple sclerosis (MS), decreased mobility, left nephrostomy tube related to kidney stones, and Foley catheter placement. The care plan directed staff to monitor for signs and symptoms of UTIs, provide perineal care, and empty the left nephrostomy as ordered.During observation on 7/1/26 at 12:42 p.m., R5 was seated in a Broda wheelchair in his room with the door open to the hallway. R5's nephrostomy drainage bag was observed hanging from the left armrest of the wheelchair. The nephrostomy tubing was positioned off the side of the wheelchair and above the insertion site, which prevented dependent drainage of urine. The position of the tubing did not allow urine to flow freely away from the insertion site and created the potential for urine backflow.During observation on 7/1/26 at 12:47 p.m., trained medication aide (TMA)-A stated R5's nephrostomy drainage bag was hung from the wheelchair armrest and that it was typically hung this way.During an interview on 7/1/26 at 1:08 p.m., the registered nurse case manager (RNCM) and director of nursing (DON) observed R5's nephrostomy drainage system. The RNCM and DON confirmed the nephrostomy bag and tubing were positioned incorrectly and stated the placement did not allow urine to drain appropriately. The DON stated the nephrostomy drainage bag needed to remain below the insertion site to allow urine to flow freely and reduce the risk of urinary tract infections (UTIs).The facility's Indwelling Catheter Care Procedure, last reviewed 5/2025, directed staff to provide appropriate care of urinary drainage systems. The policy directed staff to place drainage tubing over the resident's leg and check the tubing for evidence of urine flow.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure appropriate infection control practices were performed for 1 of 2 residents (R4) reviewed for installation of eye drops.Findings include: R4's annual Minimum Data Set (MDS), dated [DATE], indicated R4 was cognitively intact, and diagnoses included diabetes, schizophrenia, depression, and anxiety. R4's physician's orders, printed 7/2/26, indicated an order for prednisolone acetate ophthalmic suspension 1 % (corticosteroid eye drops) to his right eye after having cataract surgery. During a medication pass observation on 6/30/26 at 4:32 p.m., registered nurse (RN)-B, after setting up R4's medications, which included prednisolone eye drops, entered R4's room. RN-B gave R4 his oral meds and inhaler. RN-B instructed R4 to tilt his head back, used her ungloved fingers to spread R4's eye lids (upper and lower), held them open and instilled the eye drop in R4's right eye. RN-A offered a tissue, exited room, walked back to the medication cart and placed R4's eye drop bottle back in the cart. During an interview on 6/30/26 at 4:41 p.m., RN-A stated she forgot to wash her hands and put on gloves before R4's eye drops were administered, and RN-A stated she should have washed her hands after the eye drops were given before she left the room. RN-A stated, I forgot, I am so sorry. During an interview on 7/2/26 at 10:37 a.m., the director of nursing (DON) and corporate registered nurse (CRN) both stated RN-B should have washed her hands, donned gloves, given the eye drops, doffed her gloves and washed hands after the eye drops were administered. The facility's Eye Drop, Ointment, and Gel Medications Administration procedure, undated, indicated before the administration of eye drops, staff will perform hand hygiene, put on examination gloves, and with a gloved finger, gently pull-down lower eyelid to form a pouch. After the administration of eye drops, staff will remove gloves and wash hands thoroughly with antimicrobial soap and water or facility approved hand sanitizer.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure 1 of 5 residents (R12) were offered, educated on, and provided the pneumococcal vaccination series as recommended by the Center for Disease Control (CDC), who were reviewed for immunizations.Findings include: R12's quarterly Minimum Data Set (MDS), dated [DATE], indicated R12 admitted to the facility on [DATE], was [AGE] years of age, and diagnoses included diabetes and Parkinson's disease. R12's electronic health record (EHR) indicated R12 received PCV13 on 9/25/19, and PPSV23 on 10/22/20. The CDC's Adult Immunization Schedule, dated 10/7/25, indicated for persons [AGE] years of age and older who previously received both PCV13 and PPSV23, one dose of PCV20 or PCV21 was recommended at least 5 years after the last pneumococcal vaccine dose. R12 was eligible after 10/22/2025. However, R12's EHR lacked evidence that the resident and/or resident representative had been offered, educated on, and/or provided a PCV20 or PCV21 vaccine. During an interview on 7/2/26 at 10:20 a.m., director of nursing (DON) and assistant director of nursing (ADON) confirmed R12 was eligible for a PCV20 or PCV21, and the facility had not offered a PCV vaccine to R12.