STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thief River Care Center	2001 Eastwood Drive Thief River Falls, MN 56701

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0760 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43367 Based on document review and interview, the facility failed to ensure physician orders for an anticonvulsant medication (used to reduce/eliminate seizures) were administered without error for 1 of 3 residents (R1) reviewed. This resulted in harm for R1 when partial doses of his anticonvulsant medication were omitted during administration for 3 days and subsequently, R1 had a seizure, was transported to the emergency department (ED) by ambulance and required medical intervention. The facility implemented corrective action, so the deficient practice was issued at past non-compliance. Findings include: R1's quarterly Minimum Data Set (MDS) dated [DATE], identified moderately impaired cognition without behaviors. R1 was independent with personal hygiene, toileting, transfers, and used motorized wheelchair for mobility. R1 had a seizure disorder/epilepsy. R1's last visit with the nurse practitioner neurology dated 1/9/24, identified last known seizure was 10/16/17. Since that time frame he had been taking Lamictal, Keppra, and Zonisamide. No concerns with how he tolerated the doses, no missed doses, and no new neurological changes. R1's physician signed orders dated 7/16/24, identified: -Lamotrigine (Lamictal) (anticonvulsant drug used in treatment of epilepsy to prevent or control seizures) Oral Tablet 100 mg (milligram) 4.5 tablets by mouth one time a day every day in morning 7 a.m. to 10 a.m. for epilepsy. Special instructions: there were three packets for this medication. Order start date 5/31/22. -Lamotrigine oral tablet 100 mg 5 tablets by mouth daily at bedtime 6:30 p.m. to 10:00 p.m. for epilepsy. Special instructions: there were three packets for this medication. Order start date 5/31/22. -Levetiracetam (Keppra) (anticonvulsant drug used in treatment of epilepsy to prevent or control seizures) oral tablet 1000 mg 2 tablets by mouth two times per day every day at morning 7 a.m. to 10 a.m. and bedtime 6:30 p.m. to 10:00 p.m. for epilepsy. Order start date 5/31/22. -Zonisamide (anticonvulsant drug used to decrease abnormal electrical activity in the brain to prevent seizures) oral capsule 100 mg 2 capsules by mouth one time a day every morning 7 a.m. to 10 a.m. for epilepsy. Order start date 5/31/22. (continued on next page)

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

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F 0760 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	-Zonisamide oral capsule 100 mg 3 capsules by mouth one time every day at bedtime 6:30 p.m. to 10:00 p. m. for epilepsy. Order start date 5/31/22. R1's care plan dated 8/1/24, identified R1 took anticonvulsant medication and would not experience drug reactions. Staff were directed to administer R1's anticonvulsant medications as ordered. R1 was to be reminded to wear helmet in case of a seizure but may refuse. A safe environment was to be provided when R1 had a seizure. Monitor R1's eye movement, muscle clenching or jerking, and duration of seizure activity. Any seizure lasted more than 15 minutes should be sent to ED via 911 emergency ambulance with vitals and description of seizure activity and duration of seizure. A facility reported incident (FRI) report submitted to the State Agency (SA) filed on 7/15/24, at 9:11 a.m. identified R1 had a known seizure disorder and had a seizure on the evening of 7/14/24, in his bed. R1 was sent to ED for evaluation, lab work done, with Lamictal level pending. No medication changes at ED visit. R1 reported he felt fine on 7/15/24. R1 takes Lamotrigine oral tablet 100 mg medication order 100 mg oral tablet take 4 1/2 tablets in morning. On 7/25/24, license practical nurse (LPN) found that she had missed two pills of the 4.5 of Lamotrigine on 7/8/24, and 7/9/24. Upon investigation, found additional 2 missed pills from 4.5 on 7/14/24. R1's EMAR dated August 2024, identified: -Lamotrigine oral tablet 100 mg 4.5 tablets by mouth one time every day at morning 7:00 a.m. - 10 :00 a.m. Special instructions: there were three packets for these medications. Dose is 450 mg. All scheduled day doses were signed off as administered from 8/1/24, through 8/30/24. -Lamotrigine oral tablet 100 mg 5 tablets by mouth daily at bedtime 6:30 p.m. to 10:00 p.m. Special instructions: there were 3 packets for this medication. Dose 500 mg. All scheduled bedtime doses were signed off as administered from 8/1/24, through 8/30/24. R1's progress notes from 7/14/24, through 7/15/24, revealed: -7/14/24, at 8:27 p.m. registered nurse (RN) entered R1's room as he headed for bathroom. R1 told writer he would be a few minutes. LPN notified RN to come back into R1's room. R1 laid on his back, did not respond to verbal stimuli, and right eye did not constrict with pen light. R1's head rolled back and forth and BLE's (bilateral lower extremities) kicked out in jerking movements. VS (vital signs) taken: T (temperature) 98.1 F (Fahrenheit), BP (blood pressure) 127/84, O2 sats (oxygen saturation levels) 88% (normal range 90 to 100%) on RA (room air), RR (respirations) 24, P (pulse) 110. Writer asked LPN to call 911 as R1 was a full code and did not respond. Emergency contact notified and reported and would meet R1 at ED. R1 left with paramedics via ambulance on stretcher. Notified RN on call of R1's status via phone call. -7/15/24, at 12:24 a.m. R1 returned from ED via ambulance on stretcher, his emergency contact was with him. R1 seemed tired. R1 was to follow up with primary care provider (PCP) in three days. R1 was seen in ED for seizures had CT (cat scan) of head with contrast, EKG, and chest x-ray completed. Added appointment to book and scheduled with care provider in the morning. The above added to 24-hour report sheet. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	-7/15/24, at 8:09 a.m. incident follow-up: R1 reported felt fine no change from baseline after seizure on 7/14/24. R1 was alert and oriented, neurologically intact. Primary care provider scheduled to see R1 on 7/16 at care center and will reach out to neurologist. -7/15/24, at 4:21 p.m. R1 rested in bed, speech clear, alert, and oriented. -7/15/24, at 4:52 p.m. when nurse passed a.m. shift medications noted R1's Lamictal had doses left in the card that should have been punched out. R1's a.m. order for Lamictal 100 mg tablet, give 4 and 1/2 tabs (450 mg) by mouth in the morning. It appeared 200 mg of Lamictal had not been given on 7/7/24, 7/9/24, and 7/10/24. -Telephone encounter dated 7/15/24, with R1's Neurologist (N) and R1's family member (FM)/legal guardian. R1 had a seizure last night but had been stable for quite some time now. R1 was found unresponsive and unsure of duration. R1 had received only half dose of medication for two full days per FM after she had talked with nursing staff. N indicated since there were missed doses, no changes needed. -7/16/24, at 5:07 p.m. PCP rounded on R1. Order received to check blood pressure times one week and sent results to provider. -Follow up visit dated 7/16/24, primary provider/medical doctor (MD) identified R1 was seen during nursing home rounds. R1 accidentally received a lower dose of Lamictal 7/7/24, through 7/10/24. R1 had break through seizure 7/14/24, and seen in ED. R1's ED visit dated 7/14/24, identified [AGE] year-old male with past medical history significant for seizures with a breakthrough seizure. R1's was found slumped over with a jerking behavior and postictal (altered state of consciousness after an epileptic seizure) on arrival to ED. R1 started to answer question but clearly sedated and afebrile (without a fever). R1 was mildly hypoxic (body is deprived of adequate oxygen at the tissue level and can cause confusion and difficulty breathing) secondary to his somnolence (state of drowsiness) but once R1 woke up improvement was noted. EKG (electrocardiogram) (a recording of the hearts activity) showed sinus tachycardia (fast heart rate over 100 beats per minute) without signs of ischemia (reduction of blood flow) or dysrhythmia (irregular heartbeat). Labs were reassuring and Keppra (medication given for seizures) level was pending. CT (cat scan) of head was negative and chest x-ray were both negative. At 9:45 p.m. R1 was treated with levetiracetam (medication used to treat epilepsy seizures) in NaCl (normal saline in intravenous fluid), then at 10:14 p.m. discharged from ED and sent back to nursing home. Recommended R1 follow up with primary provider in three days on 7/17/24. R1's CT scan without contrast completed on 7/14/24, results compared with 12/25/13, revealed senescent (biological process of aging and deterioration) changes, global atrophy (loss of brain cells or number of connections between brain cells), and evidence for remote microvascular (tiny blood vessels) ischemic insults (blood vessels located in the brain that are blocked or narrowed that leads to reduced blood supply to the brain tissue) involving deep white matter (tissue located in the brain that connects nerve cells and spinal cord) for both cerebral hemispheres. There was not acute intracranial (within the skull) pathology (study of a disease and injury) suggested, no edema (swelling) or hemorrhage (bleeding). R1's lab results from 7/15/24, through 7/17/24, identified: (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	-7/14/24, Levetiracetam 1 mcg/ml (normal range 6.0 - 46.0 mcg/ml). -7/17/14, Lamotrigine 12.7 mcg/ml (micrograms/milliliters) (normal range 3.0 - 150 mcg/ml). -7/17/24, Zonisamide 14 mcg/ml (normal range 10 - 40 mcg/ml). Facility internal incident report dated 7/15/24, identified staff nursed noted when medications were passed on morning shift (a.m.) R1's Lamictal (lamotrigine) had doses left in the medication card that should have been punched out. R1's order for a.m. was Lamictal 100 mg tablet, give 4 and 1/2 tabs (450 mg) by mouth daily in the morning. It had appeared that 200 mg of the Lamictal had not been given on 7/7/24, 7/9/24, and 7/10/24. Medication sent from pharmacy in three different cards. Two cards contained 2 tabs (200 mg per card), and one card contained 1/2 tab (50 mg). It appeared that one care equaling 200 mg was not given for three days. Type of medication error: Omitted medication. R1 had a seizure on the evening of 7/14/24 and was sent to ED. Seizure possibility related to missed doses of Lamictal on 7/7/24, 7/9/24, and 7/10/24. Facility five-day report submitted to SA on 7/18/24, at 3:22 p.m. identified care plan was not followed regarding medication administration. R1 was care planned to have been provided anti-seizure medication as directed by provider. Both LPNs were interviewed and identified the process of medication administration had confused nursing staff, not all staff removed the first pill on the same side of the punch card and therefore medications were removed from the bubble packs on different days than intended. It was identified as R1's bubble pack for anti-seizure medication was messed up and not administered in sequence as should have been. R1's lab levels came back in therapeutic range, imagining of head was negative for changes, and follow up appointment scheduled with neurologist. Reviewed notes form ED visit and identified both medications were in therapeutic range and could not be determined if omission brought on seizure activity. Education was provided to staff: reviewed the process for removal of medications from bubble packs starting at same place every time and if removed from a different bubble pack staff would be expected to initial the medication card indicating that and the step-by-step process during medication administration. A laminated picture of the removal of medication sequence from punch card was placed at each nurse cart and in each nursing bible resource on each pod. Audits on all staff passing medications will be completed. During and observation/interview on 7/31/24 at 12:00 p.m., LPN-A removed R1's Lamotrigine (Lamictal) medication cards from the medication cart. LPN-A stated the cards were set up by the pharmacy to hold two weeks of medications for each dose and showed surveyor R1's morning dose of Lamotrigine (total of three cards) were empty. LPN-A indicated all R1's doses were administered as ordered for the past two weeks. LPN-A indicated some doses have more than one card such as R1's seizure medication, Lamotrigine, morning dose was provided in three separate cards: card one had Lamotrigine 100 mg tablets two in each bubble pack, card two had Lamotrigine 100 mg tablets two in each bubble pack, and card three had Lamotrigine one-half of a 100 mg in each bubble pack for a total ordered a.m. dose of 450 mg. LPN-A replaced the empty cards with the full ones and stated R1's Lamotrigine cards were labeled 1 of 3, 2 of 3, 3 of 3, to avoid future medication errors. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an observation on 7/31/24 at 1:00 p.m., a laminated document titled Easy Pak Medication System undated was seen on the medication cart. Instructions on the document included: It is important to start in the correct position on the card and to proceed correctly across the card, so that medications that are not given every day are in the correct place. At the beginning of each new cycle, start punching the card with Wednesday, on the left sift of the card, through Saturday on the bottom right, then go back to Sunday on the upper left of the card and finish out the two-week cycle. A picture of the medication punch card was included on this document to show staff a visual of where to start punching out the first dose of medication. During an observation/interview on 7/30/24 at 4:00 p.m., R1 laid in bed. R1 stated was brought to ED last Sunday due to a seizure. R1 verified had not had a seizure in years prior to that day. R1 stated the staff messed up, had not received the right dose of seizure medication, not sure how that could have happened. R1 stated had a seizure, not sure why, unaware it was going to happen, and was found lying sideways on the bed by staff. During an interview on 7/31/24 at 10:35 a.m., RN-A stated R1 had not had a seizure at this facility prior 7/14/24. RN-A stated they had not worked the day R1 had missed some medications and had a seizure. RN-A stated according to facility protocol staff were expected to have notified the provider regarding any medication error especially when a wrong dose was administered or discovered. RN-A indicated was a big deal when a wrong dose of seizure medication (Lamictal) was given especially when it was less than what was ordered for three days. RN-A confirmed R1's seizure could have been caused by that medication error. During an interview on 7/31/24 at 10:57 a.m., floor manager RN-B stated R1 had a history of seizures. RN-B indicated R1 had received only partial doses of Lamictal, 250 mg rather than the full dose ordered 450 mg in the morning on 7/7/24, 7/9/24, and 7/10/24 adding, there were three medication punch cards for R1's morning dose of Lamictal. RN-B indicated staff were expected to look at the EMAR and follow the rights of medication administration to ensure R1 received the correct dose. RN-B stated on 7/14/24, R1 laid on his bed and had a seizure. RN-B stated staff were expected to closely follow the dosing recommendations for R1's seizure medications. RN-B indicated without the correct dose administered staff caused injury and R1 had a seizure. RN-B stated the incident was reviewed in IDT (interdisciplinary team) meeting and all nursing staff attended a mandatory education meeting. RN-B stated we reviewed the rights of medication administration, the medication punch cards, where the first medication should have been removed, and medication errors. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 7/31/24 at 12:15 p.m., LPN-A stated she had missed administration of R1's Lamictal partial dose 200 mg on 7/10/24, and therefore R1 only received 250 mg of the 450 mg dose ordered that morning. LPN-A stated she had signed off on the EMAR the full dose was given but then the following Monday 7/15/24, after R1 had already had a seizure, she noticed a partial dose of 200 mg (2/100 mg tablets) remained in the bubble on the punch card for 7/10/24. Additionally, LPN-A stated there were two other dates 7/7/24, and 7/9/24, two 100 mg Lamictal pills remained inside the bubble pack on the medication card. LPN-A stated unsure how no one else noticed three of R1's Lamictal pills partial doses remained on the medication card. LPN-A verified she had reported her findings to the director of nursing (DON) on 7/15/24 right away. LPN-A verified she had received mandatory education on 7/16/24, along with most of the other staff nurses on how to best utilize the medication punch cards, medication errors and how medications were to be administered safely. LPN-A indicated the Easy Pack Medication System guide instructions were printed, laminated, and placed on the medication carts as a reference. LPN-A stated dosing recommendations should have been closely followed, especially for seizure medication because when the level of medication dropped R1 would most likely have a seizure and was required to maintain a therapeutic level. During a telephone interview on 7/31/24 at 1:35 p.m., pharmacy consultant (PC) stated R1's Lamictal had a daylong 1/2 life, and the level would slowly decrease over time if not well maintained and could certainly have contributed to a seizure. PC indicated R1 was on a therapeutic dose of Lamictal, had no seizure in years, then received a lower than ordered dose for at least three days, and had a seizure. That would have to be a pretty big coincidence, adding the decreased dose of Lamictal over three days could have contributed to a seizure especially when R1 had not had a seizure in a long time. PC stated facility staff were expected to closely follow the order, this was the final wall that avoided the seizure and when removed a seizure appeared. During a telephone interview on 7/31/24 at 2:32 p.m., medical director (MD) verified there were safety concerns when R1 only received a partial dose (250 mg rather than what was ordered 450 mg) of Lamictal which resulted in a seizure most likely due to inadequate dosing. MD stated in his opinion he was unable to rely on lab value results within the normal range, R1 still could have had a seizure due to levels that may have not been within a therapeutic range for him. MD stated the harm identified was the omission of the medication for the three days R1 received less seizure medication than what was ordered which resulted in a seizure. MD stated there was a negative outcome that compromised R1's wellbeing but no side effects such as physical injury. MD indicated this type of situation was very concerning, cannot continue to happen, and obviously a system failure. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 7/31/24 at 3:40 p.m., director of nursing (DON) confirmed R1 had a known diagnosis of epilepsy and received anticonvulsant medication. R1 had a seizure at the facility on 7/14/24 and was sent to ED via ambulance. DON verified on 7/15/24, LPN-A worked the day shift and realized there had been a medication error and the facility reported the error to the state agency since they failed to follow the resident's physician's order and care plan. DON indicted the medication card had three days on one of the three cards where 200 mg of Lamictal tablets remained in the bubble packs and therefore R1 received 250 mg instead of the ordered 450 mg for the morning dose on 7/7/24, 7/9/24, and 7/10/24. DON stated two out of the three nurses were unable to identify how the medication error occurred. DON stated all nursing staff have received education and they changed the system on the cards to identify how many cards there were (1 of 2, 2 of 3, 3 of 3). DON stated there were safety concerns for this type of medication to have been administered as a partial dose three times because of the seizure threshold could have been lowered and a seizure could have occurred. DON stated we were unable to determine the cause of the seizure and therefore determined this incident inconclusive. DON indicated the therapeutic level for anticonvulsant medication was not the same for everyone and resulted in a different threshold. DON stated each resident when initially started was required to have been regularly titrated to determine their threshold. During a telephone interview on 8/1/24 at 9:45 a.m., RN-C indicated they worked the evening shift on 7/14/24, and around 8:15 p.m. an LPN informed her R1 laid across the bed and was unresponsive. RN-C indicated when they entered R1's room he was unresponsive to verbal stimuli, head rolled back and forth, lower extremities made jerking movements, was breathing but oxygen level was slightly low at 88% so the applied oxygen, but R1 removed it. RN-C indicated they immediately called 911 as R1 had not had a seizure at this facility prior to this date, which seemed unusual, and received a lot of antiseizure medications. RN-C indicated it was important to ensure they administered the correct dose of seizure medication at the same time each day according to what was ordered to ensure R1's therapeutic levels were maintained and avoid a seizure. During a telephone interview on 8/1/24, at 10:30 a.m. primary physician (PP) stated she had seen R1 on 7/16/24, was made aware he had a seizure on 7/14/24. PP stated R1's last seizure was 2013. PP indicated additional lab work was completed but not necessarily helpful in this case unless R1 was found to be toxic from the Lamictal. PP stated R1 had received the correct dose after the seizure occurred and the level could have been lower prior to that and caused the seizure. PP also indicated R1's seizure could have been prevented and most likely resulted from receiving less that Lamictal than was ordered for those three days. During a telephone interview on 8/1/24 at 11:00 a.m., LPN-B verified she had worked the day shift on 7/9/24. LPN-B stated R1's Lamictal medication card was inappropriately started, a big mess, and attempted to straighten it out to get back into order. LPN-B stated should have pulled R1's medication card sleeve from the medication cart, contacted pharmacy, and requested a new punch card. LPN-B stated R1 had missed three days of a partial dose, was not administered as ordered, R1 most likely fell below his threshold when medication level dropped, then had a seizure due to the lowered threshold. LPN-B stated harm was caused when R1 had a seizure, transferred, and treated in the ER. LPN-B indicated they received mandatory education on 7/16/24, regarding the use of the punch medication card, starting at the same place every time, and the importance of completion of all rights of medication administration. Review of staff education documents and medication administration audits identified the facility implemented corrective action and was determined to be in compliance prior to survey entrance. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Facility policy Medication Errors dated 7/1/24, identified administration of medication would be completed in the safest way possible and according to the physician orders, to keep residents free of any significant medication errors. A significant medication error was one which caused the resident discomfort or jeopardizes his/her health safety. Any drug that altered a resident's blood level and caused negative symptoms or toxicity would be a significant medication error such as anticonvulsants. Facility policy Medication Administration dated 8/7/23, identified all medications were expected to be administered safely according to current standards of practice and regulatory requirements. Staff were directed to check the EMAR (electronic medication administration record) verify resident, medication, dose, time, and route. Remove blister pack from bin, label must be checked again the EMAR for accuracy. Appropriate dosage should be placed into souffle cup. Re-read the label against the EMAR and return blister pack to bin. Medication errors must be reported immediately to the charge nurse and/or the DON, and Physician. If significant medication error occurred physician would be notified immediately for further treatment orders.