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	01/21/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 35569 Based on interview and document review the facility failed to notify the physician of a significant medication error for 1 of 3 residents (R3) who did not receive prescribed blood pressure medication for five days. Findings include: R3's Admission Record indicated he admitted to the facility 12/3/24. R3's diagnosis included chronic atrial fibrillation (A-fib), pain, chronic kidney disease and weakness. R3's Order Summary Report dated 12/1/24 through 12/31/24, identified the following order: diltiazem hydrochloride (HCl) extended release (ER) coated beads oral capsule extended release 24 Hour 120 milligrams (mg). Give 120 mg by mouth in the morning for A-Fib. R3's Medication Administration Record dated December 2024, displayed the following for R1's diltiazem order: 12/4/24, 9- other/ see nurses notes. 12/5/24, 9- other/ see nurses notes. 12/6/24, 9- other/ see nurses notes. 12/7/24, indicated medication was administered. 12/8/24, 5- Hold/ see nurses notes. R3's Progress Notes identified the following: 12/4/24, Diltiazem HCl ER Coated Beads Oral Capsule Extended Release 24 Hour, 120 mg. Give 120 mg by mouth in the morning for A-Fib. Medication not available. (continued on next page)

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

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/5/24, Copy of signed encounter note documented by nurse practitioner (NP). I certify that the following medications have been reviewed and reconciled. Diltiazem HCl ER Coated Beads Oral Capsule Extended Release 24 Hour 120 MG, Give 120 mg by mouth in the morning for A-Fib, 120 mg, active. 12/4/2024. 12/5/24, Diltiazem HCl ER Coated Beads Oral Capsule Extended Release 24 Hour, 120 mg. Give 120 mg by mouth in the morning for A-Fib. 12/6/24, Diltiazem HCl ER Coated Beads Oral Capsule Extended Release 24 Hour, 120 mg. Give 120 mg by mouth in the morning for A-Fib. 12/8/24, Diltiazem HCl ER Coated Beads Oral Capsule Extended Release 24 Hour, 120 mg. Give 120 mg by mouth in the morning for A-Fib. Resident not on medication. Pharmacy discontinued orders upon admission. 12/9/24, Resident was sent to hospital due to being unresponsive for couple of minutes while doing physical therapy. During interview on 1/17/25 at 9:17 a.m., the director of nursing (DON) stated she was not sure why the pharmacy would say the medication was not supposed to be ordered. The DON stated not receiving the diltiazem could lead to increased blood pressure. The DON stated if a medication was not available, staff should have let her know. RN-B was present and said staff should also have updated the physician. During interview on 1/17/25 at 11:24 a.m. nurse practitioner (NP)-A stated she had not been made aware R3 had not been receiving his diltiazem. NP-A stated she was present at the facility the day R3 had the unresponsive episode and said R3 had nodded off but then was able to wake up a little bit. NP-A stated not receiving the diltiazem could have caused the unresponsive episode and could cause an irregular heartbeat and potentially some dizziness and would certainly have cause the spike in his blood pressure. Facility policy Medication Error Procedure dated 1/2020, indicated when a medication error occurs, the person responsible for the error or the person finding the error will complete the Medication Error Reconciliation Report and contact the medical provider to inform them of the error.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35569 Based on interview and document review the facility failed to ensure prescribed blood pressure medication and oxygen was administered for 2 of 3 residents (R3 and R1) reviewed. R3 had an in increase in blood pressure and R1 had an empty oxygen tank and was sent to the emergency room . Findings include: R3's Admission Record indicated he admitted to the facility 12/3/24. R3's diagnosis included chronic atrial fibrillation (A-fib), pain, chronic kidney disease and weakness. R3's Order Summary Report dated 12/1/24 through 12/31/24, identified the following order: diltiazem hydrochloride (HCl) extended release (ER) 24 Hour, 120 milligrams (mg). Give 120 mg by mouth in the morning for A-Fib. R3's Medication Administration Record dated December 2024, displayed the following for R1's diltiazem order: 12/4/24, 9- other/ see nurses notes. 12/5/24, 9- other/ see nurses notes. 12/6/24, 9- other/ see nurses notes. 12/7/24, indicated medication was administered. 12/8/24, 5- Hold/ see nurses notes. R3's Progress Notes identified the following: 12/4/24, Diltiazem HCl ER Coated Beads Oral Capsule Extended Release 24 Hour, 120 mg. Give 120 mg by mouth in the morning for A-Fib. Medication not available. 12/5/24, Copy of signed encounter note documented by nurse practitioner (NP). I certify that the following medications have been reviewed and reconciled. Diltiazem HCl ER Coated Beads Oral Capsule Extended Release 24 Hour 120 MG, Give 120 mg by mouth in the morning for A-Fib, 120 mg, active. 12/4/2024. 12/5/24, Diltiazem HCl ER Coated Beads Oral Capsule Extended Release 24 Hour, 120 mg. Give 120 mg by mouth in the morning for A-Fib. 12/6/24, Diltiazem HCl ER Coated Beads Oral Capsule Extended Release 24 Hour, 120 mg. Give 120 mg by mouth in the morning for A-Fib. (continued on next page)

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/8/24, Diltiazem HCl ER Coated Beads Oral Capsule Extended Release 24 Hour, 120 mg. Give 120 mg by mouth in the morning for A-Fib. Resident not on medication. Pharmacy discontinued orders upon admission. 12/9/24, Resident was sent to hospital due to being unresponsive for couple of minutes while doing physical therapy. 12/9/24, Chief concern/reason for transfer: Unresponsive. Vital signs; blood pressure 153/35. During interview on 1/17/25 at 9:07 a.m., licensed practical nurse (LPN)-B stated she administered R3's medication on 12/8/24 and said she noticed the other nurses had noted the medication was not available. LPN-A stated she was worried because it was an important medication, so she called the pharmacy to find out why it had not been delivered. LPN-B stated the pharmacy told her R1 was not supposed to be taking the diltiazem. LPN-B stated she had reported the medication error to the nurse manager, LPN-A. During interview on 1/17/25 at 9:11 a.m., LPN-A stated she was not aware R3 had not been receiving the diltiazem. LPN-A stated normally staff would let her know and she would call the pharmacy or ask the nurse to call. During interview on 1/17/25 at 9:17 a.m., the director of nursing (DON) stated she was not sure why the pharmacy would say the medication was not supposed to be ordered. The DON stated not receiving the diltiazem could lead to increased blood pressure. The DON stated if a medication was not available, staff should have let her know. RN-B was present and said staff should also have updated the physician. At 9:45 a.m., RN-B stated she had called the pharmacy, and they said they had no record of the order. RN-B said it looked like when the orders were sent to the pharmacy a page must have been missing. During interview on 1/17/25 at 11:24 a.m. nurse practitioner (NP)-A stated she had not been made aware R3 had not been receiving his diltiazem. NP-A stated she was present at the facility the day R3 had the unresponsive episode and said R3 had nodded off but then was able to wake up a little bit. NP-A stated not receiving the diltiazem could have caused the unresponsive episode and could cause an irregular heartbeat and potentially some dizziness and would certainly have cause the spike in his blood pressure. R1's Admission Record indicated he admitted to the facility 6/29/22 and identified diagnosis that included Chronic Obstructive Pulmonary Disease (COPD), tobacco use, hypokalemia, depressive disorder, insomnia, and cognitive communication deficit. R1's quarterly Minimum Data Set, dated dated dated [DATE], identified intact cognition and indicated he received Oxygen therapy at the facility. R1's care plan dated 7/19/24, identified and alteration of oxygen/gas exchange and respiratory status related to respiratory failure and COPD. The care plan directed staff to remind R1 not to turn up oxygen (O2) without nurse consent, monitor saturation levels as ordered, administer O2 as ordered and monitor and document on respiratory status. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Order Summary Report dated 1/1/25, identified an order dated 8/1/24; O2 per nasal annular 2-5 liters to keep saturation level greater than or equal to 88%, to prevent hypoxia every shift. R1's Progress Notes identified the following: 1/10/25, R1's blood pressure obtained with result of 94/57 millimeters of mercury (mmHg), heart rate high at 120 beats per minute (bpm) and O2 sat low at 74%. R1's oxygen was empty after assessments O2 tank was refilled and turned back to 3 liters. Vitals were reassessed and were blood pressure 104/56 mmHg, heart rate 119 (bpm), O2 89%. 1/11/25 at 1:17 a.m., R1 complained of not feeling well. Had generalized weakness, slight congestion, nausea. Medicated with Zofran 4 mg for nausea. R1 told nursing assistant (NA) he wanted to be sent out. When this writer asked resident about being sent out, he refused. 1/11/25 at 5:10 a.m., R1 was diaphoretic, lethargic, and continued to be nauseated. R1 had a large loose diarrhea. Expiratory crackles audible in right lower lobe. B/P 98/58, T 98.4, P 63, O2 saturation of 92% on 3L. Pt stated, I feel like I'm going to die. Order received to send R1 to emergency department (ED) for evaluation. Emergency services present to transport to hospital. An Emergency Medical Services (EMS) report dated 1/11/25, indicated on 1/11/25 at 4:56 a.m. EMS was dispatched to facility and arrived onsite at 4:55 a.m. R1 was assessed by EMS. Pulse, 114, respirations 34. R1 was confused, skin was pale, diaphoretic, and making incomprehensible sounds. O2, 4 liters per nasal cannula was given at 5:19 a.m. and R1's response improved. O2 10 liters was initiated at 5:32 a.m. with improved response. Additional information indicated upon EMS arrival R1 was lying on his right side, breathing was shallow and when EMS stimulated R1 he only groaned. EMS noted R1's nasal cannula was attached to a portable O2 tank that was on his wheelchair and the tank was empty. EMS changed his nasal cannula to the large O2 tank. By the time the reader picked up a reading R1's saturation level was at 75%. EMS noticed R1 was diaphoretic and soaked through his gown and sheets. R1 was moved to the ambulance and placed on a re-breather mask and his saturation level moved to 96%. During interview on 1/16/25 at 3:00 p.m., registered nurse (RN)-A stated the night R1 went to the hospital he had not been feeling well and said the NA told her he wanted to see the nurse and wanted to go to the hospital. RN-A stated when she saw R1 he told her he wanted to stay at the facility. RN-A stated R1 had been having diarrhea and felt nauseated and said the NA's cleaned him up. RN-A said when she went back to check on R1 she assessed him and said his blood pressure was low, he was not running a fever and his O2 levels were okay. RN-A stated she called and got an order to send R1 to the ED. RN-A said when she went back to tell him, he was sweating and in the fetal position and said by the time the paramedics arrived R1 was sweating to the point his sheets were wet. During interview on 1/17/25 at 9:56 a.m. The director of nursing (DON) stated R1 had gone into the hospital due to a change of condition. The DON stated the hospital had notified the facility that R1's O2 tank had been empty when EMS arrived at the facility. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 1/17/25 at 10:21 a.m., the administrator stated the hospital had reported concerns about R1's O2 tank being empty. The administrator then clarified and said the facility had access to the hospital documentation and the concern was identified when the notes were read. The DON who was present during the interview stated the facility was conducting audits of all residents who had orders for O2 but stated they had not completed any yet. The administrator stated staff had received education related to how to fill an O2 tank but stated no education had been completed related to the facility's process for ensuring tanks were filled. Facility policy Medication Error Procedure dated 1/2020, indicated when a medication error occurs, the person responsible for the error or the person finding the error will complete the Medication Error Reconciliation Report and contact the medical provider to inform them of the error. The policy further indicated the relative significance of medication errors is a matter of professional judgment. Follow three general guidelines in determining whether a medication error is significant or not: - Resident Condition - The resident's condition is an important factor to take into consideration. If the resident's condition requires rigid control, a single missed or wrong dose can be highly significant. - Drug Category - If the medication is from a category that usually requires the resident to be triturated to a specific blood level, a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. This is especially important with a medication that has a Narrow Therapeutic Index. - Frequency of Error - If an error is occurring repeatedly, there may be more reason to classify the error as significant. For example, if a resident's medication was omitted several times, it may be appropriate, depending on consideration of resident condition and medication category, to classify that error as significant.