STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245337	A. Building B. Wing	11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Linden LLC	105 West Linden Street Stillwater, MN 55082

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44647 Based on observation, interview and record review the facility failed to ensure freedom of movement was not restricted for 1 of 1 residents (R15) whose wheelchair was locked during mealtime in the dining room. Findings include: R15's quarterly Minimum Data Set (MDS) dated [DATE], indicated R15 had mild cognitive impairment and diagnoses of multiple sclerosis (a neurological disease that causes impaired walking and weakness the arms and legs), dementia with behavioral disturbance, and anxiety. R15 required total assistance with transfers, did not walk and was independent with wheelchair mobility. R15's nursing and provider orders lacked indication R15 had orders for restraints or to restrict movement when in the wheelchair. R15's care plan revised 8/12/24, indicated R15 had an alteration in socialization and at times can be disruptive during activities. Interventions included staff supervision when in an activity with R13 and encouragement to sit separately from R13. R13's annual MDS dated [DATE], indicated R13 had cognitive impairment and had diagnoses of dementia and diabetes. (continued on next page)

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 10/28/24 at 5:09 p.m., R15 was sitting in their wheelchair in the dining room. Nursing assistant (NA)-A locked R15 wheelchair on the left side and stated I'm going to leave the wheelchair locked. NA-A then moved a bedside table in front of R15 in preparation for dinner. NA-A and NA-B were delivering trays and assisting residents in the dining room. R13 was seated at a table behind and to the left of R15. At 5:13 p.m., NA-A brought R15's dinner tray and placed it in front of him. R15's left wheel remained locked. R15 started eating dinner. At 5:40, registered nurse (RN)-C entered and cleared R15's dinner tray and R15 remained seated at the bedside table. AT 5:47 p.m., R15 attempted to wheel back away from the bedside table and only the right side of the wheelchair moved and R15 stopped trying to move. RN-C then moved the bedside table away from R15 however did not unlock the left wheel. R15 again attempted to self-propel the wheelchair and was only able to wheel the right side. R15 was only able to move in a circle pivoting on the left wheel, as that wheel was still locked. At 5:49 p.m. R15 started to self-propel the wheelchair and again rolled in part of a circle. AT 5:51 p.m., R15 again rolled in a circle pivoting on the left wheel. NA-A and NA-B were in the dining room removing trays of other residents and assisting some back to their rooms. At 6:12 p. m., NA-B went to move R15 out of the middle of the room and stated oh, not going anywhere with that locked as they unlocked R15's left wheel break. At 6:15 p.m., R15 started self-propelling out of the dining room. When interviewed on 10/28/24 at 6:19 p.m., NA-B verified R15's left wheelchair wheel was locked. NA-B further stated the break was placed to help keep R15 and R13 separated during dining. NA-B stated R15 and R13 had previous physical altercations and locking R15's wheelchair prevented R15 from rolling over to R13'stable . NA- further stated R15 wonders in his chair and locking the break made sure they were separated. When interviewed on 10/29/24 at 2:39 p.m., NA-C stated R15's wheelchair should not be locked. NA-C stated R15 wouldn't know how to unlock the breaks and having them locked would be a restraint. When interviewed on 10/29/24 at 2:47 p.m., RN- C stated R15 was alert to self and was independent with wheelchair mobility. R15 had a history of being intrusive to other residents and required redirection to stay away from R13. RN-C stated staff did not lock or unlock their chair as R15 liked to move throughout the building. RN-C believed R15 did not know how to lock or unlock his wheelchair due to dementia. When interviewed on 10/31/24 at 10:06 a.m., RN-B stated staff remained in the dining room to supervise meals and residents should be able to move around how they would like to. Furthermore, wheelchair breaks should not be locked if the residents could not unlock them. If locking them was to prevent movement, it would be considered a restraint. RN-C wasn't sure if R15 could unlock their wheelchair. R15 liked to self-propel around the facility in the wheelchair and locking the breaks would be a detriment to R15. When interviewed on 10/3124 at 10:23 a.m., the Director of Nursing (DON) stated wheelchair breaks should not be locked to prevent movement of residents. DON verified that would be considered a restraint if the resident was not able to lock and unlock the breaks themselves. The facility document titled Combined Federal and State [NAME] of rights dated 2019 , directed staff to treat the residents with respect and dignity to ensure freedom from physical restraints imposed for convenience and not required to treat a medical condition.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43007 Based on interview and document review, the facility failed to manage pain consistent with the comprehensive assessment, plan of care, and physician's orders and to ensure potential acute opioid withdrawal symptoms were assessed to prevent avoidable, significant, pain for 1 of 1 resident (R23) reviewed for pain management. This deficient practice caused actual harm for R23, who experienced unmanaged pain and withdrawal symptoms. Findings include: R23's face sheet printed 10/31/24, indicated R23 had diagnosis of chronic pain syndrome with chronic opioid use related to a motor vehicle accident (MVA). R23's quarterly minimum data set (MDS) dated [DATE], indicated R23 was cognitively intact with no rejection of care. The MDS further indicated R23 had pain, however, did not receive any non-pharmacological interventions for pain. R23's pain Care Area Assessment (CAA) dated 5/7/24, indicated R23 reported pain which interfered with sleep and daily activities on an almost constant basis. Further, R23 reported constant pain rated at a 10 out of 10 on a 0-10 pain scale. Additionally, the CAA indicated R23 was at risk for pain not being adequately relieved or managed with interventions for nursing to monitor pain, administer pain medications as ordered, and nursing to update provider on pain as necessary and when pain was not adequately relieved/controlled. R23's care plan with revision date 5/17/24, indicated R23 had potential for alteration of comfort related to chronic pain syndrome, right humerus, and femur fractures, and left gluteal wound with the following interventions: pain medication as ordered by medical doctor (MD) and provide non-medicinal forms of pain relief including positioning, rest, and massage. R23's goal was to have adequate relief from pain as evidenced by verbalization, and freedom from signs/symptoms of non-verbal indications of pain. R23's physician visit note dated 10/10/24, indicated R23 had been on long-term opioid pain medications since 7/25/22 due to a motor vehicle accident and R23 reported pain intensity was an 8 on a 0-10 pain scale due to a recent fall during physical therapy which resulted in a fractured hip and shoulder. Further indicated, the physician ordered Belbuca (a strong prescription pain medicine that contains an opioid Buprenorphine. It is used to manage severe pain that requires long term treatment) 600 microgram (mcg) buccal film twice a day. R23's physician orders dated 10/31/24, indicated R23 had the following orders: -Lyrica 150 milligrams (mg) three times a day with a start date of 9/18/24 and a stop date of 10/11/24. -Lyrica 175 mg three times a day with a start date on 10/11/24. -Belbuca 900 mcg buccal film twice a day with a start date on 9/18/24 and a stop date of 10/11/24. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-Belbuca 600 mcg buccal film twice a day with a start date on 10/11/24. R23's medication administration record (MAR) dated October 2024, indicated R23 did not receive the Belbuca 600 mcg buccal film from 10/11/24 at 8:00 p.m. through 10/15/24 at 8:00 p.m., a total of 9 doses missed. The MAR further indicated R23 did not receive the Lyrica 175 mg from 10/11/24 at 8:00 p.m. through 10/14/24 at 12:00 p.m., a total of 9 doses missed. R23's progress note dated 10/14/24 at 3:46 p.m., indicated R23 had increased anxiety, agitation, fidgeting, and pacing. R23's progress note dated 10/14/24 at 10:12 p.m., indicated R23's pain medication wasn't available and exhibited withdrawal symptoms such as restlessness and agitation. Review of R23's progress notes from 10/10/24 through 10/15/24, revealed no indication of physician notification of missed pain medications, R23's pain status, or R23's withdrawal symptoms. During review of R23's electronic medical record (EMR) from 10/10/24 through 10/16/24 on 10/31/24, lacked indication of non-pharmacological interventions provided, physician notification, or new pharmacological orders provided in substitution. During an interview on 10/31/24 at 10:59 a.m., registered nurse (RN)-A stated R23's Belbuca 600 mcg and Lyrica 175 mg pain medications were not available. Further, RN-A stated R23 was miserable and a mess during the days the pain medications weren't provided. Additionally, RN-A stated R23 exhibited withdrawal symptoms of shakiness, irritability, and restlessness during the days the pain medications weren't provided. Also, RN-A stated R23 was allowed to go smoke after hours throughout the night while he was unable to sleep. During an interview on 10/31/24 at 11:35 a.m. R23 stated, I felt awful, my pain was through the roof, my pain was completely out of control and they didn't do anything for my pain. Further, R23 verified the facility staff did not provide any non-pharmacological interventions during the time the pain medications weren't provided. During an interview on 10/31/24 at 11:43 a.m., registered nurse manager (RN-B) stated was informed by the nursing staff the pharmacy didn't send the new prescribed medications due to it was too early to fill the medications so, the medical provider was contacted on 10/16/24 regarding the missing pain medications. RN-B further stated the issue was the previous Belbuca and Lyrica medications were destroyed since R23 was given new prescriptions for the Belbuca and Lyrica. Additionally, the Belbuca prescription was sent to the wrong pharmacy and the facility had to call and have the pharmacy release the prescription so the facility pharmacy could fill and send the medication. During an interview on 10/31/24 at 1:26 p.m. the DON verified the nurses should have called the pharmacy when the medication wasn't received and should have updated the physician right away if the pharmacy couldn't send the medication. During an interview on 10/31/24 at 1:30 p.m., pain specialty physician stated the facility should have notified the office as soon as the medication wasn't received so an alternative could have been given. Further, the MD indicated if an opioid medication was stopped abruptly severe withdrawal symptoms could occur as well as increased pain. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	During an interview on 11/1/24 at 12:34 p.m. the administrator stated the facility administration was made aware on Monday 10/14/24 of R23 not receiving the new pain medications. Further, verified the medications were not received and given in a timely manner when the facility didn't receive the ordered medications. During an interview on 11/1/24 at 1:33 p.m., nurse practitioner (NP) verified they did not complete a comprehensive assessment of R23's pain or withdrawal symptoms on 10/14/24. During review of the prescribing information on Belbuca.com on 10/31/24, revealed a warning: Serious and Life-threatening risks from use of Belbuca indicated serious, life-threatening, or fatal respiratory depression may occur with use of Belbuca, especially during initiation or following a dosage increase. To reduce the risk of respiratory depression, proper dosing, and titration of Belbuca are essential. The Highlights of Prescribing Information obtained from Belbuca.com website indicated not to abruptly discontinue Belbuca in patients who may be physically dependent on opioids. Rapid discontinuation of opioid analgesics in patients who are physically dependent on opioids has resulted in serious withdrawal symptoms, uncontrolled pain, and suicide. Rapid discontinuation has also been associated with attempts to find other sources of opioid analgesics, which may be confused with drug-seeking for abuse. Patients may also attempt to treat their pain or withdrawal symptoms with illicit opioids, such as heroin, and other substance. The Pain Management Protocol dated 3/23/23, indicated to ensure that residents with pain or at risk for pain, have an effective pain management plan in place with individualized interventions that are consistent with the resident's goals for comfort. Treatment/Management 1. With input from the resident and/or resident representative, the provider, and staff will establish goals of pain treatment, for example, freedom from pain with minimal medication side effects, less frequent headaches, or improved functioning, mood, and sleep. 2. Nursing will evaluate for appropriate non-pharmacologic interventions to address the individual's pain. 3. Provider will order appropriate medication interventions to address individuals' pain. 4. The staff will evaluate and report how much and how often the resident utilizes PRN pain medication. a. Depending on severity and location of pain, the provider may start with PRN doses or supplement routine doses with PRN doses for breakthrough pain. (continued on next page)

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