Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 23, 2025

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

RE: CCN: 245298
Cycle Start Date: January 9, 2025

Dear Administrator:

On January 9, 2025, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting

the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F"and/or an "E" tag), i.e., the plan of correction should be directed to:

Terri Ament, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by April 9, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by July 9, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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 _____	C 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**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 1/16/25 through 1/21/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed H52985165C (MN00109818) with deficiencies cited at F580 and F760. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a	F 580		2/7/25

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

Electronically Signed — 02/07/2025

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.

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F 580	Continued From page 1 deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by:	F 580		

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F 580	Continued From page 2 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. 12/5/24, Copy of signed encounter note	F 580	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. F580- Notify of Changes, s/s D¿ -The process for satisfying this requirement has been reviewed and revised as needed, to ensure physicians are appropriately notified of significant medication errors.¿	

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F 580	Continued From page 3 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	F 580	-All residents who receive medication have the potential to be affected if this regulation is not met.¿ -R3 was sent to the hospital for medical evaluation and necessary intervention, and did not return to the facility.¿¿ -All other residents who require medication were reviewed to ensure that no missing medications, proper follow-up with pharmacy, and physician notification has been completed. -All necessary staff received education regarding the requirement to notify a medical physician of any significant medication errors and the process for missing medications. -Compliance audits will be completed by the director of nursing and/or designee three (3) times weekly for two (2) weeks, two (2) times weekly for two (2) weeks, one (1) time weekly for two (2) weeks, and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence.¿ -Corrective action will be completed on or before 2/7/2025.¿	

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F 580	Continued From page 4 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.	F 580		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: 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.	F 760	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set	2/7/25

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F 760	Continued From page 5 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.	F 760	forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. F760- Residents are Free of Significant Med Errors, s/s D -The process for satisfying this requirement has been reviewed and revised as needed, to ensure residents receive their prescribed medications, specifically blood pressure medications and oxygen.¿ -All residents prescribed blood pressure medications and oxygen have the potential to be affected if this regulation is not met.¿ -R1 and R3 were sent to the hospital for medical evaluation and necessary intervention/treatment, and did not return to the facility.¿¿ -All residents requiring blood pressure medications were reviewed for any missed doses. Residents requiring the use of supplemental oxygen were reviewed for any abnormal oxygen saturations and the	

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F 760	Continued From page 6 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. 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	F 760	availability of oxygen supply. -All necessary staff received education regarding significant medication errors, medication error process, and notification of physician. -Compliance audits for missing medications, oxygen administration, and medication errors will be completed by the director of nursing and/or designee three (3) times weekly for two (2) weeks, two (2) times weekly for two (2) weeks, one (1) time weekly for two (2) weeks, and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence.¿ -Corrective action will be completed on or before 2/7/2025.¿	

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F 760	Continued From page 7 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 12/17/24, 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	F 760		

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F 760	Continued From page 8	F 760		

oxygen (O2) without nurse consent, monitor saturation levels as ordered, administer O2 as ordered and monitor and document on respiratory status.

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

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	245298	A. BUILDING _____ B. WING _____	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 9 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	F 760		

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F 760	Continued From page 10 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. 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	F 760		

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F 760	Continued From page 11 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.	F 760		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 23, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: DHH711

Dear Administrator:

The above facility was surveyed on January 7, 2025 through January 9, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Terri Ament, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 1/16/25 through 1/21/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were	2 000		

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2 000	Continued From page 1 issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed: H52985165C (MN00109818) with licensing orders issued at 0265 and 1545. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be	2 000		

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2 000	Continued From page 2 corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications;	2 265		2/7/25

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2 265	Continued From page 3 C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: 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.	2 265	Corrected	

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2 265	Continued From page 4 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. 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	2 265		

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2 265	Continued From page 5 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. SUGGESTED METHOD OF CORRECTION: The facility could review policies and procedures and train staff related to notifications to the provider. The Director of Nursing (or designee) could conduct measurable audits on residents health records and bring to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring.	2 265		

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2 265	Continued From page 6 TIME PERIOD FOR CORRECTION: twenty-one (21) days.	2 265		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record.	21545		2/7/25

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21545	Continued From page 7 C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: 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.	21545	Corrected	

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21545	Continued From page 8 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. 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.	21545		

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21545	Continued From page 9 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.	21545		

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21545	Continued From page 10 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 12/17/24, 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. 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	21545		

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21545	Continued From page 11 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	21545		

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21545	Continued From page 12 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. 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	21545		

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21545	Continued From page 13 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	21545		

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21545	Continued From page 14 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. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for medication errors. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure medications were correctly administered. The quality assurance committee could monitor these measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21545		