Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H52988143M
Compliance #: H52987422C

Date Concluded: March 23, 2026

Name, Address, and County of Licensee Investigated:
The Estates at Twin Rivers
305 Freemont Street
Anoka, MN 55303
Anoka County

Facility Type: Nursing Home

Evaluator's Name:
Katherine Barnhardt RN, Special Investigator

Finding: Inconclusive

Nature of Investigation:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557.

Initial Investigation Allegation(s):
The alleged perpetrator (AP), licensed facility staff, neglected the resident when the resident received an increased dose of Haldol (treats schizophrenia) medication for seventeen consecutive days and was hospitalized.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Licensed facility staff conducted an internal investigation and were unable to determine how the dose was increased. Within the pharmacy's integrated system, the pharmacy was identified as the source of the dose change, and the AP's credentials approved the dose change. The AP denied approving the pharmacy's dose change. Although the resident's Haldol was increased, it could not be determined who was responsible.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a pharmacy and a family member. The investigation included review of the resident record(s), hospital records,

pharmacy records, facility internal investigation, facility incident reports, personnel files, staff schedules, related facility policy and procedures.

The resident resided in a skilled nursing facility. The resident's diagnoses included schizoid personality disorder and depression. The resident's care plan included assistance with medication administration. The resident's assessment indicated cognitive impairment and assistance with most activities of daily living (ADL).

The resident record indicated the resident admitted to the facility with medication orders. Haldol was ordered 10 milligrams (mg) daily at bedtime. The residents electronic medication record (EMAR) indicated 10 mg of Haldol was administered daily for four days and on the fifth day the Haldol directions changed to 100 mg daily. The resident received Haldol 100 mg daily for seventeen consecutive days. On the seventeenth day a decline in the residents condition was observed and a provider was notified. The resident record indicated the provider reviewed the medications administered, noted the Haldol dose error and sent the resident to an emergency room.

Pharmacy records indicated Haldol was initially ordered 10 mg one tab daily at bedtime. Five days later, Haldol orders changed in the pharmacy's system to 100 mg, five 20 mg tabs daily at bedtime. The dose revision was electronically recorded into the pharmacy system with the time, date, name and title of the AP. Pharmacy did not question the significant dose change and sent the higher dose to the facility.

A facility transfer document indicated medication overdose as the reason the resident transferred to a hospital.

Hospital records indicated the resident was diagnosed with acute toxic encephalopathy (rapid cognitive and neurological impairments) due to accidental Haldol overdose. Hospital records indicated the resident was hospitalized twenty-eight days, improved with treatment and discharged to a new facility.

During an interview conducted in a federal investigation, a pharmacist stated the significant dose increase was received electronically and normally would have been questioned or flagged, however, because the previous dose was discontinued at the time of the revision, the order was presumed correct and processed. A pharmacist stated it was unusual for Haldol to increase from 10 mg to 100 mg so quickly.

During an interview, the AP stated she had not entered the resident's admit orders and denied approving the 100-milligram dose for Haldol in the pharmacy's electronic system. The AP stated she did not have an explanation for her information time stamped on the dose revision and it was possible another licensed staff had made the dose approval under her log in information.

During an interview, a licensed staff stated orders were generated to the pharmacy through a variety of systems. The facility's integrated pharmacy system alerted all licensed staff of orders, dependent on what settings staff used on their dashboard (facility electronic notification system). When pharmacy generated a medication order licensed staff verified the facility had the same order and approved it on the integrated system. Licensed staff stated she spoke with pharmacy and was told that because the medication change included a discontinuation date on the original order, the dose revision was not flagged. Licensed staff stated she spoke with providers that issued orders for the resident, none had issued the order and to this day she is unable to explain why the Haldol order changed.

During an interview, leadership stated she was not familiar with the medication portals or systems, however an internal investigation was completed. A second licensed staff that was a possible source of the Haldol dose change had not been contacted during the internal investigation and the AP consistently denied involvement in the dose change. Leadership stated a new order required two licensed staff to double check and approve; a revised order required one licensed staff. Leadership completed a review of the facility's medication systems after the incident and processes were changed.

During an interview, a family member stated the resident experienced a medication dose error and was hospitalized. Family stated the resident experienced physical and cognitive changes prior to the incident and lasting side effects of the error were difficult to determine.

In conclusion, the Minnesota Department of Health determined neglect was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: No
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:

The facility requested a provider review and sent the resident to an emergency room.

Action taken by the Minnesota Department of Health:
MDH previously investigated the issue during a complaint survey under federal regulations, and substantiated facility noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:
https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html.

You may also call 651-201-4200 to receive a copy via mail or email.

The purpose of this investigation was to determine any individual responsibility for alleged maltreatment under Minn. Stat. 626.557, the Maltreatment of Vulnerable Adults Act.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/04/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates At Twin Rivers Llc	**305 FREMONT STREET , ANOKA, Minnesota, 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
20000	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: The Minnesota Department of Health investigated an allegation of maltreatment, complaint #H52987422C, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. No correction orders are issued. The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State	20000		

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

Minnesota State Department of Health

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20000	Continued from page 1 form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	20000		