STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. Building B. Wing	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Greeley LLC	313 South Greeley 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 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49338 Based on observation, interview, and document review the facility failed to accurately transcribe an order for an anti-convulsant (anti-seizure medication) upon admission for 1 of 3 (R1) residents reviewed for medication administration in accordance with physician instructions. This resulted in actual harm for R1 when he had seizures and required treatment in the hospital. The facility had taken action to prevent this type of medication error from occurring again, therefore is being cited at past noncompliance. Findings include: R1's facesheet dated 6/25/24, indicated R1 was admitted on [DATE] from an acute care hospital with diagnoses including generalized idiopathic epilepsy and epileptic syndromes not intractable without status epilepticus (a seizure disorder). R1's hospital Medicine History & Physical dated 6/4/24, noted R1 had a history of epilepsy and cognitive disorder. It identified a diagnosis of generalized convulsive epilepsy with a plan to continue with home dosing of 1250 mg [milligrams] BID [twice a day] Depakote [anti-convulsant medication]. R1's Hospital Care Management document's Medication List from the discharging hospital dated 6/6/24, included two admission orders for the medication divalproex (divalproex sodium, the generic for medication with brand name Depakote, sometimes shortened to just divalproex). The first order was for divalproex 500 mg delayed release tablet, take two tablets (1000 mg) by mouth twice a day along with 250 mg tablet for total dose of 1250 mg. The second was for divalproex 250 mg delayed release tablet, take one tablet twice daily. The document included handwritten check marks next to the orders and was signed 1st check with date 6/6/24 and initials of the health information manager (HIM). R1's Transfer Orders from the discharging hospital dated 6/6/24, included two admission orders for the medication divalproex. The first order was for divalproex 500 mg delayed release tablet, take two tablets (1000 mg) by mouth twice a day along with 250 mg tablet for total dose of 1250 mg. The second was for divalproex 250 mg delayed release tablet, take one tablet twice daily. The document included handwritten brackets around the medication order set including these orders and was signed with the initials of licensed practical nurse (LPN)-A and dated 6/6/24 at 2:50 p.m. (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 0760 Level of Harm - Actual harm Residents Affected - Few	R1's Hospital Discharge Summary Report dated 6/6/24, included a discharge medication list with instruction to continue taking these medications that included divalproex 500 mg delayed release tablet, take two tablets (1000 mg) by mouth twice a day along with 250 mg tablet for total dose of 1250 mg and divalproex 250 mg delayed release tablet, take one tablet twice daily. R1's electronic health record (EHR) contained a doctor's order dated 6/6/24, for divalproex sodium oral tablet delayed release give 1250 mg by mouth at bedtime scheduled for administration every day at bedtime. The order was confirmed by LPN-A and had a start date of 6/6/24 and was discontinued on 6/18/24. R1's medication administration record [MAR] dated 6/1/24 to 6/30/24, included the order for divalproex sodium oral tablet delayed release with instruction give 1250 mg by mouth at bedtime scheduled for HS ([NAME] somni, abbreviation for bedtime). The administration was charted as complete from 6/6/24 through 6/15/24. A progress note dated 6/16/24, indicated R1 experienced a change of condition and had a petit mal seizure lasting five minutes and then a grand mal seizure lasting three minutes and was sent to the hospital via ambulance. A progress noted dated 6/16/24, indicated staff called the local hospital emergency room and R1 was still there, he continued to have seizures and would be transferred to a larger hospital. A hospital Clinical Pharmacy Therapeutic Drug Monitoring Note dated 6/16/24, noted R1 received a loading dose [large one-time dose of a medication] of valproic acid of 2500 mg intravenously at 6:23 a.m. with valproic acid level [the body converts divalproex into valproic acid] of 32 prior to the administration. The plan indicated increase valproic acid from 1250 mg BID to 1250 mg intravenously (due to R1's inability to swallow at the time) every eight hours, an increase in dosing from 18 mg of medication per kilogram of R1's weight per day to 28 mg of medication per kilograms of R1's weight per day. There were two lab results of valproic acid listed, a value dated 6/16/24 of 32 micrograms per milliliter (mcg/mL) identified as L indicating lower than the normal range, and a value of 12/27/2018 of 59 mcg/mL not identified as out of normal range. The note indicated R1 was ordered to receive valproic acid [and other anti-convulsant medications]. Pharmacy has been consulted to manage dosing and monitoring to achieve therapeutic levels. A physician's General Medicine Progress Note dated 6/17/24, included [R1] is a 62 y.o. [year old] male with epilepsy . who was admitted from TCU to [local hospital] with seizures and transferred to [larger hospital] for status epilepticus. A physician's hospital Neurocritical Care Progress Note dated 6/17/24, included a clinical summary that noted on 6/16 he [R1] has a seizure at the TCU and was taken to [local hospital]. He had a couple of additional seizures while at [local hospital] despite receiving [multiple intravenous anti-convulsant medications]. He had another seizure after arriving at [larger hospital to which he was transferred]. He is chronically on lamotrigine [an anti-convulsive] and valproic acid for his epilepsy. He has been sleeping poorly lately. In ED [emergency department], lamotrigine level was normal at 13.3 but VPA [valproic acid] was low at 32. The assessment and plan for convulsive status epilepticus and generalized epilepsy noted etiology perhaps sleep deprivation and subtherapeutic VPA level and to continue maintenance VPA. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	A physician's hospital Neurological Consultation Note dated 6/18/24, included impression: breakthrough status epilepticus, history of epilepsy. Patient reports AED [antiepileptic drug] compliance and good seizure control, first seizure in 3 years. Etiology likely related to subtherapeutic Depakote. No clear evidence of infection, toxicity, or metabolic derangements. The history of present illness noted Depakote level resulted subtherapeutic and reportedly there was concern that he wasn't getting some of his scheduled meds at the TCU. A physician's hospital Medicine Progress Note dated 6/18/24, noted a lab result for VPA level of 62. The reference range for VPA normal lab values listed was from 50 to 100 mcg/mL. The hospital's MAR for R1 indicated R1 received 1250 mg of valproate sodium (generic name of a medication equivalent to Depakote that is also converted into valproic acid by the body) with instruction to infuse intravenously every eight hours on 6/16/24 at 1:29 p.m. and 10:40 p.m., 6/17/24 at 8:42 a.m. 3:15 p.m. and 10:31 p.m., and on 6/19/24 at 8:27 a.m. Nursing Home Incident Report number 356938 submitted by the facility to the State Agency (SA) by the director of nursing (DON) on 6/19/24, included [R1] admitted to the facility on [DATE] to the TCU [transitional care unit] for a rehab[ilitation] stay while recovering for a displaced open fracture of the left lower leg. While on the TCU, [R1] experienced a petit mal and a grand mal seizure. Patient was transferred to the hospital for further evaluation and treatment, where he was admitted for Breakthrough Convulsive Status Epilepticus . Upon case review, it was discovered [R1] was receiving prescribed seizure treating medication of Divalproex Sodium and Lamotrigine. When reviewing the doses of medications, it was discovered the patient admitted with an order of 1250 mg of Divalproex BID but in error received 1250 mg Q Day [daily]. This appears due to a transcription error in order placement. A progress note dated 6/19/24, indicated R1 was readmitted to the facility at 12:11 p.m. Hospital Transfer Orders from the hospital to the facility dated 6/19/24, included orders for divalproex 500 mg delayed release tablet with instructions take two tablets (1000 mg) by mouth twice a day along with 250 mg tablet for total dose of 1250 mg and divalproex 250 mg delayed release tablet with instructions take one tablet twice daily. R1's EHR contained provider orders dated 6/19/24, for divalproex sodium delayed release 500 mg tablet with instruction to give 1000 mg by mouth two times a day . take with 250 mg tablet for total dose of 1250 mg BID and divalproex sodium delayed release 250 mg tablet with instruction to give 250 mg by mouth two times a day . take with 1000 mg tablet for total dose of 1250 mg BID. R1's MAR dated 6/1/24 to 6/30/24, included the orders for divalproex sodium delayed release 250 mg and 500 mg tablets scheduled for administration at 8:00 a.m. and 8:00 p.m. for a total dose of 1250 mg twice daily. The administrations were all charted as complete beginning with the 8:00 p.m. dose on 6/19/24. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	In an interview on 6/24/24 at 2:10 p.m., LPN-A stated HIM put in admission orders for resident and a nurse second checks them. LPN-A stated somehow there was a transcription error with R1's Depakote order and neither herself nor the HIM caught it. She noted R1's anti-seizure medication was put in with the incorrect frequency, it should have been administered morning and night but was put in just for night, and so R1 was not at a therapeutic level of the medication. LPN-A stated she did not understand how it was missed and noted it was a case of human error. During observation and interview on 6/24/24 at 2:34 p.m., registered nurse (RN)-A confirmed that the medication cart contained medication cards for R1 for divalproex tablets that were labeled with date dispensed of 6/6/24. One prescription was cards of divalproex delayed release 500 mg tablets with instructions give two tablets (1000 mg) by mouth twice daily with 250 mg to = 1250 mg twice daily. The second prescription was cards of divalproex delayed release 250 mg tablets with instructions give one tablet (250 mg) by mouth twice daily with 1000 mg to = 1250 mg twice daily. RN-A stated when administering medications she opened the MAR and compared the prescription information on the medication such as resident and drug names, time of administration, frequency, and dose to the information in the MAR. RN-A indicated if she identified a discrepancy she would check for any new provider orders scanned into the resident's chart and if there were no new orders, would refer back to the original admission orders from the hospital for clarification. During an interview on 6/24/24 at 2:46 p.m., R1 stated he was at the facility because he broke his ankle but then had a seizure at the facility and went to the hospital where he believed he had five seizures before re-admitting to the facility. R1 did not recall any concerns regarding his medications. During an interview on 6/24/24 at 3:00 p.m., HIM stated when a new admission was approved and faxed orders were initially received, she would input the orders into a queue for the nurses to then look at. She stated when a resident arrived at the facility, they would have a set of discharge orders from the hospital with them and the nurses would then go through the queued orders she had entered and check to ensure they matched the second set of orders the resident arrived with. HIM noted she hand signed the faxed orders after queueing them, the nurse hand signed the second set of orders after confirming them, and the orders were then scanned into resident EHRs. HIM stated she did not remember inputting R1's orders but was aware a transcription error had occurred. In an interview on 6/25/24 at 9:41 a.m., LPN-A stated when administering medications nurses compare the medication card to the MAR to make sure they are the same patient, medication, dose, form, frequency, and time. If there was a difference, she would pull up the full order for the medication in the EHR and look for the scanned copy of the original orders and if they were different she would call the doctor and clarify. LPN-A stated she performed these checks every time for every medication. LPN-A indicated she did not remember noting a difference between the information on R1's divalproex card and his MAR. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	In an interview on 6/25/24 at 10:28 a.m., the pharmacist in charge (PC) for the facility's pharmacy stated there was no standard dosing for Depakote, but most of what the pharmacy saw was 125 mg four times daily or twice daily up to about 500 mg, it was dependent on the individual patient's condition and typically monitored via lab work. The PC noted the frequency of lab work varied based on the provider and patient, but typically included liver enzymes, a complete blood count, and a Depakote level. The PC stated low lab levels of Depakote could be caused by most likely, the most obvious, would be not giving doses to patients in a timely manner . the most obvious one [cause] would be missing the doses. The PC identified that for an individual taking Depakote for epilepsy, a possible outcome would be the patient would then have symptoms or epilepsy if they were missing doses and it was prescribed for twice daily but given daily. The PC noted a bigger possibility of this happening for a patient taking a higher dose of Depakote and he would consider 1250 mg twice daily to be a high dose, if it was only being administered once a day instead of twice a day it is possible that would trigger their [an individual with this dosing's] epilepsy symptoms. In an interview on 6/25/24 at 12:39 p.m., the DON stated R1 had experienced seizures while at the facility and staff called paramedics and transferred him to the local hospital which then transferred him to a larger hospital. The DON noted that she was updated by the hospital that he would be returning to the facility and because I like to look into details, I started looking into all of his orders from when he was here before, and I noticed the discrepancy [in the Depakote orders] . when I heard he was coming back I particularly wanted to look at his seizure meds because he'd left with a seizure and that's when it became evident and that's when I filed the report [with the SA]. The DON noted she believed the incident was a case of human error and LPN-A knew the process for transcribing admission orders. The DON stated she expected nursing staff to compare the orders in the MAR against the information on a medication card prior to administration every time they administer a medication. She noted the error with R1's Depakote was concerning because it could cause harm if he did not get his anti-convulsive medication as ordered and confirmed that he did not receive the Depakote in accordance with provider orders from 6/6/24 to 6/16/24 while at the facility. During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included the following actions to correct the non-compliance and were able to demonstrate monitoring of the corrective action and sustained compliance: During an interview on 6/25/24 at 12:39 p.m. DON stated that upon discovering R1's medication transcription error, house audits were performed to ensure all orders entered on admission in EHRs corresponded with original hospital admission orders for all residents on the TCU, all new admissions, and all residents taking medications for seizures. She noted audits were performed of other resident charts to ensure current orders were all correct. The DON noted hospital admission orders had a new third check by nursing management to ensure orders were entered correctly which had already been implemented. The DON identified no errors in order entry through the audit process. The DON noted nursing management was performing ongoing audits of orders to ensure they were accurate. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Facility document titled PNC QAPI & Internal 4 Point Plan of Correction dated 6/19/24, of a Quality Assurance and Performance Improvement meeting held on 6/19/24 addressing the medication error and steps taken for correction included: Immediate corrective action for those affected: Patient was transferred to [hospital] on 6/16. Staff responsible for error received education and corrective action, Process/steps to identify others having the potential to be affected: House-wide audit for new admissions for the current month. Therapeutic dosing medications will pull labs to get baseline levels and put orders to repeat those labs every three months, Measures put in to place/systemic changes to mitigate recurrence: Nursing leadership will conduct audits to ensure resident's orders are being inputted accurately. Education on Medication Transcription Errors must be reviewed and understood prior to next shift, Plan to monitor performance: Audits done by Nurse Leadership team to ensure orders are accurate, and Education provided: education on Medication Transcription Errors. Faciliy education record dated 6/19/24, included documentation of education provided on 6/19/24 and an ongoing basis about order transcription with signatures indicating completion by all nursing staff who had worked since that date. Policy titled Admission Order Transcription, undated, was provided and outlined the policy and procedure for transcribing orders and performing double-checks and was reviewed with staff in this education. Facility policy titled Medication and Treatment Orders dated 2/2024, included Orders for medications and treatments will be transcribed accurately and in a timely fashion. Orders must include: a. Name and strength of the drug; b. Number of doses, start and stop date, and/or specific duration of therapy; c. Dosage and frequency of administration; d. Route of administration; e. Clinical condition or symptoms for which the medication is prescribed; and f. Any interim follow-up requirements (pending culture and sensitivity reports, repeat labs, therapeutic medication monitoring, etc.). Facility policy titled Medication Error Procedure dated 1/2020, included Determining Significance: 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 titrated 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 (NTI); 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. Facility policy titled Process for Medication Transcription, undated, included 10.Type in and choose Medication without the dosage if possible; 11. Choose the Route of Administration; 12. Click Routine/PRN under Scheduling details; 13. Add in Dose/Admin quantity; 14. Add in Frequency; 15. Add in Schedule Type; 16. Add Facility time Code; 17. Add in Related Diagnosis (Click on the Search icon (magnifying glass to see list if diagnosis not there see HID to add); 18. For PRN you type in the Indications for use not Diagnosis; 19. Add additional Directions if any are needed; 20. Check Start date to make sure it is correct; 21. If there is an end Date, make sure to add in how long the resident needs to take the medication for - if there is no stop/end date, leave as Indefinite; 22. Check the pass times to make sure the code is AM/PM/HS unless a specific time is needed; 23. Check your order before hitting queue and new or save.