Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL356785841M
Compliance #: HL356788207C

Date Concluded: November 26, 2024

Name, Address, and County of Licensee Investigated:
Generations Home Care
Address: 119 3rd Ave. SE
St. Joseph, MN 56374
Stearns County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Jana Wegener, RN, Special Investigator

Finding: Not Substantiated

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, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The resident was neglected when the facility failed to provide safe accurate medication administration services resulting in omission of numerous medications.
In addition, the resident was financially exploited when the Alleged Perpetrator (AP) was observed on video surveillance alter documentation and take the resident's medication.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident's medication administration record lacked documentation of numerous medications. The resident had no negative outcome and the allegation did not rise to the level of neglect. However, licensing orders were issued related to the facility's inconsistent medication monitoring.
Financial exploitation by drug diversion was not substantiated. The AP altered the resident's medication documentation and put the resident's medication in her pocket. The medication the AP put in her pocket was not controlled substances, and the AP indicated she was trying to

fix a prior medication error. There was no indication the AP took the residents medication for her own personal use.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of the resident record(s), facility internal investigation, facility incident reports, personnel files, staff schedules, related facility policy and procedures. Also, the investigator observed facility video surveillance, staff, and residents at the facility.

The resident resided in an assisted living facility with diagnoses including post-polio syndrome, osteoarthritis, deep vein thrombosis (DVT), thrombolytic disorder with long term anticoagulant use, migraines, fibromyalgia, hypothyroidism, hypertension, and asthma.

The resident's admission assessment and service plan indicated the resident was unable to administer her own medications and indicated the facility would provide medication administration services. The resident's service plan indicated the resident would receive medications as ordered by an authorized provider.

The resident's medication administration records (MAR) for August and September had more than 120 administration errors and/or omissions (blanks in documentation) indicating the medications were not administered as ordered. The MAR indicated several critical medications including blood pressure medication, blood thinner, anticoagulants, oxygen, and controlled drug pain medication were not administered as ordered.

Although the resident's MAR included weekly medication monitoring completed by a facility nurse and indicated the medication administration services provided were monitored, evaluated, and verified the medications/treatments were given correctly. Due to the lack of documentation in the resident record there was no way to verify the resident received the medications as ordered. The weekly medication monitoring failed to identify the discrepancies, and the resident record showed the errors continued to occur.

The resident record indicated only 3 medication administration errors were reported in August and September. One medication error report indicated the AP failed to administer a dose of the resident's Gabapentin at 8:00 p.m. 6 days later an incident report indicated the AP was observed on facility video surveillance footage pocket a dose of the resident's gabapentin and levothyroxine.

A facility investigation indicated the facility video surveillance was reviewed which showed the AP alter the administration dates documented on the bubble pack card and pocketed the resident's medications. The investigation indicated the AP admitted she put the pills in her pocket and stated she had changed the dates because they were wrong.

A review of the facility video surveillance clip (approximately 5 minutes long) showed the AP altering dates on the bubble pack card and put the resident's medications into her pocket. The video showed the AP appeared to be visibly upset as she communicated with another ULP at the medication cart. Although the conversation could not be heard, the AP was observed repeatedly pointing to her scrub pocket during the interaction with the ULP and appeared to be showing the ULP where she had placed the resident's pills.

When interviewed the ULP working with the AP the night of the incident stated the AP accused him of making a medication error the night of the incident, but indicated the AP was confused and no error was made.

When interviewed facility leadership stated when the AP was confronted with the conduct observed on video, the AP stated the ULP working with her had made a medication error, and she changed the dates on the bubble pack because they were wrong, then pocketed the pills to put them into the medication destruction box.

When interviewed the resident stated she had no concerns she had not received her medications as ordered and indicated she had no adverse effects including increased pain.

The resident's family member stated things were going well for the resident, and denied the resident had any complaints/concerns of adverse effects to indicate medications may not have been given as ordered.

When interviewed the AP stated the night of the incident, she assisted the ULP with passing medications because he was new and did not feel comfortable completing the task alone. The AP stated she noticed the resident's pills scheduled at 8PM remained in the bubble pack for that day/time, so she punched them out to administer. The AP indicated the ULP stated he had already given the resident's medication from another bubble which was not previously given. The AP stated she put the pills into her pocket to destroy because the resident had already received the medication. The AP stated she was distracted and forgot to put the pills into the medication destruction box. The AP stated she fixed the dates on the bubble pack card because she thought they were incorrect. The AP denied any wrongdoing and denied taking or diverting the resident's medications.

In conclusion, the Minnesota Department of Health determined neglect and financial exploitation were not substantiated.

"Not Substantiated" means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment 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.

Financial exploitation: Minnesota Statutes, section 626.5572, subdivision 9
"Financial exploitation" means:
(a) In breach of a fiduciary obligation recognized elsewhere in law, including pertinent regulations, contractual obligations, documented consent by a competent person, or the obligations of a responsible party under section 144.6501, a person:
(1) engages in unauthorized expenditure of funds entrusted to the actor by the vulnerable adult which results or is likely to result in detriment to the vulnerable adult; or
(2) fails to use the financial resources of the vulnerable adult to provide food, clothing, shelter, health care, therapeutic conduct or supervision for the vulnerable adult, and the failure results or is likely to result in detriment to the vulnerable adult.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility investigated the concern and reported the concern to the Minnesota Adult Abuse Reporting Center. The AP is no longer employed by the facility.

Action taken by the Minnesota Department of Health:
The facility was found to be in 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

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

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

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 CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL356785841M/#HL356788207C On October 17, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 6 residents receiving services under the provider's Assisted Living license. The following correction order is issued for #HL356785841M/#HL356788207C, tag identification 1690, and 1760.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is 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. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
01690 SS=G	144G.71 Subdivision 1 Medication management services	01690		

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01690	Continued From page 1 (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on document review and interview the licensee failed to provide safe accurate medication administration services for one of one residents (R1) under the supervision and direction of a registered nurse, or licensed	01690		

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01690	Continued From page 2 healthcare professional including verifying medications were administered as prescribed, resolving medication errors, and ensuring the security and accountability of controlled substances. R1 was at risk for harm when more than 120 error/omissions occurred. In addition, R1 had more than one as needed (PRN) nitroglycerin order for chest pain with no clear direction for staff on which medication to use when, what monitoring to provide, and when to notify the nurse/provider, or call 911. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to the licensee on July 27, 2024, with diagnoses including post-polio syndrome, osteoarthritis, deep vein thrombosis (DVT), thrombolytic disorder with long term anticoagulant use, migraines, fibromyalgia, hypothyroidism, hypertension, and asthma. The resident's admission assessment dated July 27, 2024, and service plan indicated R1 was unable to administer her own medications and indicated the facility would provide medication administration services. R1's service plan indicated R1 would receive medications as ordered by an authorized provider. R1's MAR for August and September 2024, had	01690		

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01690	Continued From page 3 over 120 errors and omissions (blanks in documentation) indicating the medications were not administered as ordered. The MAR indicated several critical medications including blood pressure medication, blood thinner, anticoagulants, oxygen, and controlled drug pain medication were not administered as ordered. In addition, the MAR indicated licensed practical nurse (LPN)-H had completed weekly medication monitoring to ensure R1 received medications as ordered. A review of R1's medication errors for August and September 2024, indicated only 3 were reported. As a result, the licensee failed to identify or take action to ensure safe accurate medication administration services were provided to R1, and the errors continued to occur. The resident's MAR indicated the following medications were not given as ordered. - Xarelto 20 milligrams (mg) (a blood thinner), with orders to take one tablet daily with breakfast, scheduled at 8:00 a.m. R1's August 2024, MAR indicated the medication was not given on August 29, 2024, at 8:00 a.m. - Lisinopril 2.5 mg, with orders to take daily for hypertension, scheduled at 8:00 a.m. R1's August 2024, MAR indicated the medication was not given on August 29, 2024, at 8:00 a.m. - Protonix 40 mg, with orders to take before breakfast and supper, scheduled at 7:30 a.m., and 4:30 p.m. R1's August and September 2024, MAR indicated the medication was not given 3 times. - Nifedipine 60 mg, with orders to take orally for esophageal spasm, scheduled at 8:00 a.m. R1's August and September 2024, MAR indicated the medication was not given 2 times. - Gabapentin 300 mg capsule, with orders to take two capsules PO three times daily (TID) for polymylitis (many inflammation of the spinal cord	01690		

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01690	Continued From page 4 related to polio), scheduled at 8:00 a.m., 2:30 p.m., and 8:00 p.m. R1's August and September 2024, MAR indicated the medications were not given 12 times. - Docusate Sodium 8.6-50 mg tab, with orders to take BID for constipation, scheduled at 8:00 a.m., and 8:00 p.m. R1's August 2024, MAR indicated the medications were not documented as given 3 times. - Pulmicort inhaler, with orders to administer one puff BID and rinse mouth after, scheduled at 8:00 a.m., and 8:00 p.m. R1's August and September 2024, MAR indicated the medication was not documented as given 31 times. - Fluticasone 50 mcg nasal spray, with orders to spray one spray in both nostrils daily for allergies, scheduled at 8:00 a.m. R1's August and September 2024, MAR indicated the medication was not documented as given 8 times. - Cranberry Tablets 15000 mg, with orders to take one tablet PO daily (supplement), scheduled at 8:00 a.m. R1's August and September 2024, MAR indicated the medication was not documented as given 2 times. - Multivitamin, with orders to take PO daily, scheduled at 8:00 a.m.. R1' August and September 2024, MAR indicate the medication was not documented as given 2 times. - Melatonin 5 mg (supplement), with orders to give 4 gummies every night, scheduled at 8:00 p.m. R1's August and September 2024, MAR indicated the medication was not documented as given 10 times. - Aspirin 81 mg (antiplatelett) with orders to take every other day. R1's August and September 2024, MAR indicated the medication was not given as ordered on August 1, 2024, to August 7, 2024, when R1 received the medication daily instead of every other day. As a result, R1 received the medication in error 3 times, and did	01690		

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01690	Continued From page 5 not receive the medication as prescribed one time. - Lipitor 10 mg take one tab at bed time for cholesterol and diabetes, scheduled at 8:00 p.m.. R1's August and September 2024, MAR indicated the medication was not documented as given 6 times. - Levothyroxine 25 mcg take one tab at bedtime for thyroid, scheduled at 8 p.m. R1's August and September 2024, MAR indicated the medication was not documented as given 5 times. - Nortriptyline 75 mg, with orders to take one capsule at bedtime for fibromyalgia, scheduled at 8:00 p.m. R1's August and September 2024, MAR indicated the medication was not documented as given 5 times. - Oxygen via nasal canula at night 8 liters per minute, with instructions to apply at bedtime (HS) and remove/turn off in AM. R1's August and September 2024, MAR indicated oxygen administration was not documented as completed 19 times. - Tramadol 50 mg (a controlled drug pain medication) with instructions to take 2 tabs to equal 100 mg BID for pain, scheduled at 8:00 a.m., and 8:00 p.m. R1 August and September 2024, MAR indicated the medication was not documented as given 11 times. R1's August 2024, narcotic tracking logs for Tramadol 8:00 a.m. and Tramadol 8:00 p.m., indicated 2 staff counted the medication at change of shift at a 7:00 a.m., 3:00 p.m., and 11:00 p.m. The tracking log indicated no monitoring or tracking to prevent diversion of the residents controlled drug Tramadol occurred from R1 admission on July 27, 2024, to August 5, 2024, at 11:00 p.m. when the count on both tracking logs started at 60 tablets. - On August 6, 2024, the 8:00 a.m. Tramadol	01690		

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01690	Continued From page 6 tracking/counting log indicated the count remained 60, unchanged from the previous day, indicating no medication was given as ordered. - On August 12, 2024, the 8:00 a.m. Tramadol tracking/counting log indicated the count remained 50, unchanged from the previous day, indicating no medication was given as ordered - On August 6, 2024, the 8:00 p.m. Tramadol tracking/counting log indicated the count remained 60, unchanged from the previous day, indicating no medication was given as ordered. - On August 12, 2024, the 8:00 p.m. Tramadol tracking/counting log indicated the count was 48, then on August 13, 2024, the count was 44, indicating (decreased by 4 instead of 2) indicating 2 Tramadol tablets were unaccounted for, a concern for potential diversion. R1 record failed to indicate any concerns with the resident's narcotic tracking to prevent diversion, or omission of administration of the scheduled medication were identified, or reported. R1's MAR included nurse medication monitoring scheduled weekly, which was documented as completed by LPN-H on August 12, 2024, August 19, 2024, August 26, 2024, September 3, 2024, September, 9, 2024, September 16, 2024, and September 24, 2024. Despite LPN-H documenting weekly medication monitoring was completed, there was no indication any concerns including omissions, errors, or controlled drug tracking were identified. R1's MAR included a list of PRN orders included 2 orders for nitroglycerin to be given for chest pain. The first order was Nitroglycerin 0.4 mg with instructions to give one tablet under the tongue as needed for chest pain, may repeat every 5 minutes, 3 times for a maximum of 3 doses. The MAR also included orders for Nitroglycerin patch	01690		

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01690	Continued From page 7 0.2 mg/hour with instructions to apply one patch onto the skin daily as needed for chest pain. The licensee failed to provide clear instruction to staff on which nitroglycerin to use (the patch or oral) when, if they can be used together, what monitoring should be done if nitro was given, and when to communicate to the nurse, provider, or call 911. - On September 5, 2024, at 2:32 p.m. the PRN log indicated the Nitroglycerin patch was administered for chest pain level 7, with relief noted at 3:46 p.m. R1's progress notes failed to indicated the resident had chest pain or a PRN was given. R1's record failed to indication the nurse or provider were notified, or what actions were taken for R1 including monitoring R1's vital signs. R1's record had no vital sign monitoring documented. - On September 8, 2024, at 5:55 p.m. the PRN log indicated the Nitroglycerin patch was administered with no improvement 2 hours later. At 8:00 p.m. the PRN log indicated oral Nitroglycerin 0.4 mg was given for chest pain level 7, with no relief at 8:30 p.m. R1's progress note on September 8, 2024, indicated R1 had chest pain, however there was no indication the nurse or provider were notified, and no indication what actions were taken for R1 including monitoring vital signs. R1's record had no vital sign monitoring completed. On November 5, 2024, at 4:30 p.m. unlicensed personnel (ULP)-A stated they were trained to provide medication administration services to residents. ULP-A stated they had observed medications not given/still in the bubble pack cards, and incorrect documentation dates in R1's record. On November 5, 2024, at 11:34 a.m. ULP-G	01690		

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01690	Continued From page 8 indicated she was the house supervisor. When asked what her role was as a supervisor ULP-G indicated the nurses were responsible to oversee ULP staff and delegated medication administration services including review of MAR and narcotic logs to ensure medications were given correctly, accurately, with no discrepancies. ULP-G stated if there were blanks in documentation on the MAR she would have staff come in a sign for what they had given. On November 5, 2024, at 10:51 a.m. ULP-D stated she had noticed medications not given for R1 before and blanks in the MAR. ULP-D indicated if there was a blank in the MAR she would look at the bubble pack to see if the med was given, then tell the staff to sign for the medication they gave. On November 5, 2024, at 12:45 p.m. Registered Nurse (RN)-C stated he was not aware of the blank omissions on R1 MAR, and stated if it was not documented it was not done. RN-C stated he was unaware of discrepancies in R1's narcotic log. When the findings were reviewed with RN-C he verified something was not right with R1's Tramadol log count which was a concern for possible diversion. RN-C verified no one had reported any of the aforementioned concerns to him and indicated monitoring of the ULP delegated to provide medication administration services was the responsibility of the house supervisor who was also a ULP. RN-C indicated the ULP house supervisor should be reviewing the MAR's and narcotic logs daily, and should have reported the concern, but had not. RN-C stated the licensee did not provide medication administration services to R1 when she was first admitted because she came with her own medications and they had no orders. RN-C	01690		

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01690	Continued From page 9 verified there was no narcotic tracking to prevent diversion of R1's Tramadol prior to August 5, 2024. On November 5, 2024, at 11:47 a.m. Licensed Practical Nurse (LPN)-H was asked about weekly medication monitoring documented in the MAR, and LPN-H stated she provided oversight by looking over the MAR's, bubble packs, and narcotic logs to make sure things done correct and accurately. When the errors and omissions in R1's MAR were reviewed with LPN-H stated she knew the medication was given to R1 because they were gone from R1's bubble pack cards. LPN-H stated she was surprised there were so many blanks in R1 MAR, and stated I think everything was given because I know the people who work here. LPN-H stated if it was not documented it was not given, and verified she had not noticed the lack of documentation in the MAR with her weekly reviews. LPN-H stated R1 had no controlled drug tracking in place prior to prevent diversion prior to August 5, 2024, because she came with her own medications, and no narcotic tracking to prevent diversion was implemented until the R1's bubble packs were delivered from the pharmacy. LPN-H stated R1 brought and administered her own medications including Tramadol prior to August 5, 2024, so the licensee was not responsible to count/track that medication to prevent diversion. A facility policy and procedure titled "Medication Management - Administration and Setup" dated August 1, 2021, indicated the licensee would document any medication administration provided accurately in each resident record. Procedure section 9. indicated staff would chart in each resident's medication administration record any problems with medication administration,	01690		

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	35678	A. BUILDING: _____ B. WING _____	C 10/17/2024

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01690	Continued From page 10 including refusals. Section 10. indicated staff would also document any reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. A facility policy and procedure titled "Medication & Treatment - Administration and Delegation" dated August 1, 2021, indicated ordered or prescribed medications and or treatments/therapy may be administered by a nurse, physician, or other licensed health practitioner authorized to administer medications or to perform the treatment or therapy, or by unlicensed personnel who have been delegated medication administration tasks by a registered nurse. When administration of medications or treatment/therapy was delegated or assigned to unlicensed personnel, the licensee would ensure that the registered nurse would provide specific instructions for each resident and documented those instructions in the resident's records. Section e) Indicated staff would document after assistance with medication reminder or medication administration, including the date, time, dosage, and method of administration of all medications, or the reason why medication was not administered as ordered. A facility policy and procedure titled "Narcotic Log" dated August 1, 2021, Section 2. indicated all schedule II controlled substances would be counted and recorded on the narcotic count sheets and compared with the current medication quantities. This will occur at the start and end of the day shift, the start and end of the evening shift, and the start and end of the overnight shift.	01690		

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01690	Continued From page 11 This count will be recorded on the narcotic count sheets specific to the resident. Section 6. Indicated the accuracy of the count would be documented by the staff initials on the narcotic count sheet to include the date it is performed. The nurse will verify the documentation on the clients narcotic count sheets, including counts and records regularly. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days.	01690		
01760 SS=G	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure medication was administered as prescribed for one of one residents (R1). R1's medication administration record (MAR) lacked documentation of	01760		

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01760	Continued From page 12 administration (over 120) for numerous medications. R1 was at risk for harm with the omission of numerous critical medications including blood thinner, anticoagulant, and scheduled pain medication which were not documented as administered. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to the licensee on July 27, 2024, with diagnoses including post-polio syndrome, osteoarthritis, deep vein thrombosis (DVT), thrombolytic disorder with long term anticoagulant use, migraines, fibromyalgia, hypothyroidism, hypertension, and asthma. The resident's admission assessment dated July 27, 2024, and service plan indicated R1 was unable to administer her own medications and indicated the facility would provide medication administration services. R1's service plan indicated R1 would receive medications as ordered by an authorized provider. R1's MAR for August and September 2024, had over 120 errors and omissions (blanks in documentation) indicating the medications were not administered as ordered. The MAR indicated several critical medications including blood pressure medication, blood thinner,	01760		

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01760	Continued From page 13 anticoagulants, oxygen, and controlled drug pain medication were not administered as ordered. In addition, the MAR indicated licensed practical nurse (LPN)-H had completed weekly medication monitoring to ensure R1 received medications as ordered. A review of R1's medication errors for August and September 2024, indicated only 3 were reported. As a result, the licensee failed to identify or take action to ensure safe accurate medication administration services were provided to R1, and the errors continued to occur. The resident's MAR indicated the following medications were not given as ordered. Xarelto 20 milligrams (mg) (a blood thinner), with orders to take one tablet daily with breakfast, scheduled at 8:00 a.m. The MAR indicated the medication was not given on: - August 29, 2024, at 8:00 a.m. Lisinopril 2.5 mg, with orders to take daily for hypertension, scheduled at 8:00 a.m. The MAR indicated the medication was not given on: - August 29, 2024, at 8:00 a.m. Protonix 40 mg, with orders to take before breakfast and supper, scheduled at 7:30 a.m., and 4:30 p.m. The MAR indicated the medication was not given 3 times on: - August 29, 2024, at 7:30 a.m. - September 1, 2024, at 8:00 a.m., and 8:00 p.m. Nifedipine 60 mg, with orders to take orally for esophageal spasm, scheduled at 8:00 a.m. The MAR indicated the medication was not given 2 times on: - August 29, 2024, at 8:00 a.m. - September 18, 2024, at 8:00 a.m. Gabapentin 300 mg capsule, with orders to take 2	01760		

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01760	Continued From page 14 capsules three times daily (TID) for polymylitis (many inflamation of the spinal cord related to polio), scheduled at 8:00 a.m., 2:30 p.m., and 8:00 p.m. The MAR indicated the medications were not given 12 times on: - August 1, 2024, at 8:00 p.m. - August 2, 2024, at 2:30 p.m. - August 4, 2024, at 2:30 p.m. - August 6, 2024, at 8:00 p.m. - August 7, 2024, at 8:00 p.m. - August 8, 2024, at 8:00 p.m. - August 13, 2024, at 2:30 p.m. - August 16, 2024, at 8:00 p.m. - August 23, 2024, at 8:00 p.m. - August 29, 2024, at 8:00 a.m., and 2:30 p.m. - September 10, 2024, at 8:00 p.m. R1 medication error/discrepancy incident reports for August and September 2024, included only 3 reports indicating on August 13, 2024, at 2:30 p.m., on August 21, 2024, at 8:00 p.m. and on August 29, 2024, at 2:30 p.m. R1 was not given Gabapentin as ordered. Docusate Sodium 8.6-50 mg tab, with orders to take BID for constipation, scheduled at 8:00 a.m., and 8:00 p.m. The MAR indicated the medications were not documented as given 3 times on: - August 7, 2024, at 8:00 p.m. - August 23, 2024, at 8:00 p.m. - August 28, 2024, at 8:00 p.m. Pulmicort inhaler, with ordered to administer one puff BID and rinse mouth after, scheduled at 8:00 a.m., and 8:00 p.m. The MAR indicated the medication was not documented as given 31 times on: - August 1, 2024, at 8:00 a.m., and 8:00 p.m. - August 2, 2024, at 8:00 a.m., and 8:00 p.m. - August 3, 2024, at 8:00 p.m.	01760		

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01760	Continued From page 15 - August 4, 2024, at 8:00 p.m. - August 5, 2024, at 8:00 a.m. - August 6, 2024, at 8:00 p.m. - August 8, 2024, at 8:00 p.m., - August 9, 2024, at 8:00 a.m. - August 10, 2024, at 8:00 a.m. - August 11, 2024, at 8:00 a.m. - August 12, 2024, at 8:00 a.m. - August 13, 2024, at 8:00 a.m., and 8:00 p.m. - August 14, 2024, 8:00 a.m. - August 15, 2024, at 8:00 a.m. - August 16, 2024, at 8:00 a.m., and 8:00 p.m. - August 17, 2024, at 8:00 a.m., and 8:00 p.m. - August 20, 2024, 8:00 a.m., and 8:00 p.m. - August 27, 2024, at 8:00 p.m. - August 29, 2024, at 8:00 a.m. - August 30, 2024, at 8:00 p.m. - August 31, 2024, at 8:00 p.m. - September 4, 2024, at 8:00 p.m. - September 5, 2024, at 8:00 p.m. - September 12, 2024, at 8:00 p.m. - September 17, 2024, at 8:00 p.m. Fluticasone 50 mcg nasal spray, with orders to spray one spray in both nostrils daily for allergies, scheduled at 8:00 a.m. The MAR indicated the medication was not documented as given 8 times on: - August 1, 2024, at 8:00 a.m. - August 2, 2024, at 8:00 a.m. - August 3, 2024, at 8:00 a.m. - August 4, 2024, at 8:00 a.m. - August 5, 2024, at 8:00 a.m. - August 6, 2024, at 8:00 a.m. - August 20, 2024, at 8:00 a.m. - August 29, 2024, at 8:00 a.m. Cranberry Tablets 15000 mg, with orders to take one tablet PO daily (supplement), scheduled at 8:00 a.m. The MAR indicated the medication was	01760		

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01760	Continued From page 16 not documented as given 2 times on: - August 20, 2024, at 8:00 a.m. - August 29, 2024, at 8:00 a.m. Multivitamin, with orders to take PO daily, scheduled at 8:00 a.m.. The medication was not documented as given on: - August 20, 2024, at 8:00 a.m. - August 29, 2024, at 8:00 a.m. Melatonin 5 mg (supplement), with orders to give 4 gummiest every night, scheduled at 8:00 p.m. The MAR indicated the medication was not documented as given 10 times on: - August 6, 2024, at 8:00 p.m. - August 10, 2024, at 8:00 p.m. - August 11, 2024, at 8:00 p.m. - August 12, 2024, at 8:00 p.m. - August 13, 2024, at 8:00 p.m. - August 14, 2024, at 8:00 p.m. - August 16, 2024, at 8:00 p.m. - August 17, 2024, at 8:00 p.m. - August 18, 2024, at 8:00 p.m. - August 27, 2024, at 8:00 p.m. Aspirin 81 mg (antiplatelett) with orders to take every other day. The MAR indicated the medication was not given as ordered on August 1, 2024, to August 7, 2024, when R1 received the medication daily instead of every other day. The resident received the medication in error on: - August 2, 2024, at 8:00 a.m. (received in error) - August 4, 2024, at 8:00 a.m. (received in error) - August 6, 2024, at 8:00 a.m. (received in error) - On August 29, 2024, at 8:00 a.m. the resident did not receive the medication as prescribed. Lipitor 10 mg take one tab at bed time for cholesterol and diabetes, scheduled at 8:00 p.m.. The MAR indicated the medication was not	01760		

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01760	Continued From page 17 documented as given 6 times on: - August 1, 2024, at 8:00 p.m. - August 6, 2024, at 8:00 p.m. - August 7, 2024, at 8:00 p.m. - August 15, 2024, at 8:00 p.m. - August 16, 2024, at 8:00 p.m. - August 31, 2024, at 8:00 p.m. Levothyroxine 25 mcg take one tab at bedtime for thyroid, scheduled at 8:00 p.m. The MAR indicated the medication was not documented as given 5 times on: - August 1, 2024, at 8:00 p.m. - August 6, 2024, at 8:00 p.m. - August 15, 2204, at 8:00 p.m. - August 16, 2024, at 8:00 p.m. - August 31, 2024, at 8:00 p.m. Nortriptyline 75 mg, with orders to take one capsule at bedtime for fibromyalgia, scheduled at 8:00 p.m. The MAR indicated the medication was not documented as given 5 times on: - August 1, 2024, at 8:00 p.m. - August 6, 2024, at 8:00 p.m. - August 15, 2024, at 8:00 p.m. - August 16, 2024, at 8:00 p.m. - August 31, 2024, at 8:00 p.m. Oxygen via nasal cannula at night 8 liters per minute, with instructions to apply at bedtime (HS) and remove/turn off in AM. The MAR indicated oxygen administration was not documented as completed 19 times on: - August 11, 2024, at HS - August 12, 1024, at HS - August 14, to August 21, 2024, at HS - August 27, 2024, at HS - August 29, 2024, at HS - September 5, 2024, at HS - September 7, 2024, at HS	01760		

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01760	Continued From page 18 - September 19, 2024, at HS - September 21, 2024, at HS - September 23, to September 25, 2024, at HS Tramadol 50 mg (a controlled drug pain medication) with instructions to take 2 tabs to equal 100 mg BID for pain, scheduled at 8:00 a.m., and 8:00 p.m. The MAR indicated the medication was not documented as given 11 times on: - August 1, 2024, at 8:00 p.m. - August 6, 2024, at 8:00 p.m. - August 10, 2024, at 8:00 p.m. - August 15, 2024, at 8:00 p.m. - August 16, 2024, at 8:00 p.m. - August 24, 2024, at 8:00 p.m. - August 26, 2024, at 8:00 a.m. - August 27, 2024, at 8:00 p.m. - August 29, 2024, at 8:00 a.m. - August 31, 2024, at 8:00 p.m. - September 16, 2024, at 8:00 p.m. R1's MAR included nurse medication monitoring scheduled weekly, which was documented as completed by LPN-H on August 12, 2024, August 19, 2024, August 26, 2024, September 3, 2024, September, 9, 2024, September 16, 2024, and September 24, 2024. Despite LPN-H documenting completing weekly medication monitoring, there was no indication any concerns including omissions, errors, or controlled drug tracking were identified. As a result, R1 record indicated the errors continued to occur. On November 5, 2024, at 4:30 p.m. unlicensed personnel (ULP)-A stated they were trained to provide medication administration services to residents. ULP-A stated they had observed medications not given and still in the bubble pack cards, and incorrect documentation dates in R1's	01760		

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01760	Continued From page 19 record. On November 5, 2024, at 11:34 a.m. ULP-G indicated she was the house supervisor. When asked what her role was as a supervisor ULP-G indicated the nurses were responsible to oversee ULP staff and medication administration services including review of MAR and narcotic logs to ensure medications were given correctly, accurately, with no discrepancies. ULP-G stated if there were blanks in documentation on the MAR, she would have staff sign for what they had given. On November 5, 2024, at 10:51 a.m. ULP-D stated she had noticed medications not given for R1 before, and blanks on the MAR. ULP-D indicated if there was a blank in the MAR she would look at the bubble pack to see if the med was given, then tell the staff to sign for the medications they gave. On November 5, 2024, at 12:45 p.m. Registered Nurse (RN)-C stated he was not aware of the blank/omissions, or errors on R1 MAR, and stated if it was not documented it was not done. RN-C verified no one had reported any of the aforementioned concerns to him and indicated monitoring of the ULP delegated to provide medication administration services was the responsibility of the house supervisor who was also a ULP. RN-C indicated the ULP house supervisor should be reviewing the MAR daily, and was responsible to report any concerns, but had not. On November 5, 2024, at 11:47 a.m. Licensed Practical Nurse (LPN)-H was asked about weekly medication monitoring documented in R1's MAR, and LPN-H stated she provided oversight by looking over the MAR's, bubble packs, and	01760		

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01760	Continued From page 20 narcotic logs to make sure things were done correct and accurately. When asked about and reviewed the errors and omissions in R1's MAR LPN-H stated she knew the medication was given because they were gone from R1's bubble pack cards. LPN-H stated she was surprised there were so many blanks in R1 MAR, and stated she thought everything was given because she knows the people who work at the facility. LPN-H stated if it was not documented it was not given, and verified she had not noticed the lack of documentation in the MAR with her weekly reviews. A facility policy and procedure titled "Medication Management - Administration and Setup" dated August 1, 2021, indicated the licensee would document any medication administration provided accurately in each resident record. Procedure section 9. indicated staff would chart in each resident's medication administration record any problems with medication administration, including refusals. Section 10. indicated staff would also document any reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. A facility policy and procedure titled "Medication & Treatment - Administration and Delegation" dated August 1, 2021, indicated ordered or prescribed medications and or treatments/therapy may be administered by a nurse, physician, or other licensed health practitioner authorized to administer medications or to perform the treatment or therapy, or by unlicensed personnel who have been delegated medication	01760		

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GENERATIONS HOME CARE INC	119 3RD AVENUE SE SAINT JOSEPH, MN 56374

(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) COMPLETE DATE
01760	Continued From page 21 administration tasks by a registered nurse. When administration of medications or treatment/therapy was delegated or assigned to unlicensed personnel, the licensee would ensure that the registered nurse would provide specific instructions for each resident and documented those instructions in the resident's records. Section e) Indicated staff would document after assistance with medication reminder or medication administration, including the date, time, dosage, and method of administration of all medications, or the reason why medication was not administered as ordered. A facility policy and procedure titled "Narcotic Log" dated August 1, 2021, Section 2. indicated all schedule II controlled substances would be counted and recorded on the narcotic count sheets and compared with the current medication quantities. This will occur at the start and end of the day shift, the start and end of the evening shift, and the start and end of the overnight shift. This count will be recorded on the narcotic count sheets specific to the resident. Section 6. Indicated the accuracy of the count would be documented by the staff initials on the narcotic count sheet to include the date it is performed. The nurse will verify the documentation on the clients narcotic count sheets, including counts and records regularly. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days.	01760		