STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245265	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Francis Home	2400 St Francis Drive Breckenridge, MN 56520

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 49620 Based on observation, interview and document review, the facility failed to ensure medications were administered according to the standard of practice for 8 of 13 residents (R1, R2, R4, R5, R7, R8, R9, R10) reviewed for medication administration. Findings include: R1's physician order summary dated 7/18/24, identified the following medications were ordered: Tylenol 325 milligrams (mg) by mouth give two tablets (650 mg) three times a day. Sucralfate give one gram by mouth two times a day. R2's physician order summary dated 8/15/24, identified the following medications were ordered: Calcium-Vitamin D 600-400 mg-unit by mouth daily. CertaVite Senior multivitamin by mouth daily. Cranberry 500 mg by mouth daily. Dalfampridine Extended Release 12 hour give 10 mg by mouth twice a day. Eliquis 2. 5 mg by mouth twice a day. Famotidine 20 mg by mouth daily. Gabapentin 600 mg by mouth three times a day. Iron 325 mg by mouth daily every Monday, Wednesday, Friday. Lasix 20 mg by mouth daily every Monday, Wednesday, Friday. Losartan Potassium-Hydrochlorothiazide 100-12.5 mg by mouth daily. Metformin Extended Release 500 mg give two tabs (1000 mg) by mouth daily. Potassium Chloride Extended Release 10 milliequivalent (meq) by mouth daily every Tuesday, Wednesday, Thursday, Saturday, Sunday. Seroquel 50 mg by mouth twice daily. Tizanidine 4 mg by mouth daily. Toprol Extended Release 25 mg; Give 50 mg daily. R3's physician order summary dated 8/15/24, identified the following medications were ordered: Gabapentin 100 mg by mouth three times a day. Systane Ultra ophthalmic solution 0.4-0.3%; Instill 1 drop in both eyes three times a day. R4's physician order summary dated 9/5/24, identified the following medications were ordered: Benefiber powder; Give 3 teaspoons (tsp) by mouth daily. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245265	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Francis Home	2400 St Francis Drive Breckenridge, MN 56520

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R5's physician order summary dated 8/28/24, identified the following medications were ordered:. Cholestyramine powder 4 grams (gm) by mouth in the morning for loose stools mix with 4-8 ounce orange juice- given at least one hour post other meds. Allopurinol 100 mg by mouth daily. Apixaban 2.5 mg by mouth twice daily. Aspirin 81 mg by mouth daily. Bumex 1 mg by mouth twice daily. Cipro 500 mg by mouth twice daily. Ferrous Sulfate 325 mg by mouth daily. Gabapentin 600 mg by mouth four times daily. Hydralazine 25 mg by mouth twice daily. Lexapro 20 mg by mouth daily. Losartan 50 mg by mouth daily. Metoprolol 75 mg by mouth twice daily. Multivitamin 1 tab by mouth daily. Rosuvastatin 5 mg by mouth in the morning. Vitamin C 500 mg by mouth twice daily. R6's physician order summary dated 9/10/24, identified the following medications were ordered: Letrozole 2. 5 mg by mouth daily in the afternoon. R7's physician order summary dated 9/10/24, identified the following medications were ordered: Tylenol 1000 mg by mouth three times a day. R8's physician order summary dated 8/15/24, identified the following medications were ordered: Tylenol Extra Strength 500 mg; Give 1000 mg by mouth three times a day. R9's physician order summary dated 9/4/24, identified the following medications were ordered: Tramadol 50 mg; Give 25 mg by mouth three times a day. Tylenol 1000 mg by mouth three times a day. R10's physician order summary dated 8/15/24, identified the following medications were ordered: Tylenol 1000 mg by mouth three times a day. Buspirone 30 mg by mouth twice daily. R11's physician order summary dated 9/10/24, identified the following medications were ordered: Cosopt ophthalmic solution 22.3-6.8 mg/milliliter (ml); Instill one drop in right eye three times a day. R12's physician order summary dated 8/28/24, identified the following medications were ordered: Artificial tears ophthalmic solution instill one drop in both eyes three times daily. R13's physician order summary dated 9/4/24, identified the following medications were ordered: Ferrous Sulfate 325 mg by mouth twice daily. During an observation on 9/11/24 at 11:57 a.m., trained medication aide (TMA) stood by the medication cart outside of R1's room. TMA unlocked the cabinet in R1's room, removed Tylenol 325 mg two tabs and Sucralfate one tab and placed medications in a plastic medication cup. TMA locked the cabinet and pushed the cart down the hall and returned the cart near the nurses station. The following were observed on top of the medication cart: -Plastic glass with a white powder substance covering one quarter of the bottom of the glass. -Silver/white colored packet of a powder substance. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245265	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Francis Home	2400 St Francis Drive Breckenridge, MN 56520

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	TMA took plastic glass, the white powder substance, an empty plastic glass, silver/white colored packet and the medications in the plastic medication cup to the dining room. TMA set medication cup with the medications in it on the table in front of R1. R1 took the medications and placed the medication cup down on the table. TMA took the empty medication cup and threw the cup in the garbage by the kitchenette area. TMA entered kitchenette, poured a red colored juice into the glass with the white powder substance, poured orange juice into the empty glass, walked over to R4 and set the glass of red juice on table in front of R4. TMA picked up a straw, stirred the juice and walked over to another table and set the orange juice on the table in front of R5. TMA opened the silver/white colored packet of the powder substance and poured into the orange juice. TMA stirred the juice with a straw and exited the dining room. TMA did not observe R4 or R5 drink the juice in front of them. At 12:04 p.m., TMA walked to the medication cart, filled a glass of water, unlocked the cart and removed a plastic medication cup from the top drawer with an unknown number of medications in it. TMA walked to the conference room and gave R2 the medications in the cup. R2 took the medications and handed the cup back to TMA. TMA returned to the cart, signed out the medications on the computer and signed out Gabapentin in the controlled medication book for R2. TMA proceeded to push the cart to R6's room, unlocked the medication cupboard in R6's room, walked to the bathroom, put on two pairs of gloves, removed Letrozole 2. 5 mg from cupboard, placed into plastic medication cup and gave to R6. TMA returned to the cart, sanitized hands and removed two plastic medication cups from the top of the cart. TMA wrote names on the cup and proceeded to R7's medication cupboard, removed Tylenol 500 mg two tabs, placed in cup and left the cup on top of medication cart. TMA moved the cart to the other side of the hall and opened R8's medication cupboard. TMA removed Tylenol 500 mg two tabs, placed in the other cup and placed the cup on the top of the cart. TMA brought cart up to main nurses station, crushed R7's medications, placed R8's medication cup in the top drawer of the cart. At the time, another plastic medication cup with an unknown number of medications in it was observed to be in the top drawer of the medication cart. TMA brought crushed medications in chocolate pudding to R7, R7 took the medications and TMA returned to the cart and sanitized hands. TMA signed out R7's medications on the computer, unlocked the cart, removed R8's medications and delivered to R8 in the dining room. R8 took the medications,TMA returned to the medication cart and signed out R8's medications on the computer. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245265	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Francis Home	2400 St Francis Drive Breckenridge, MN 56520

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 12:21 p.m., TMA pushed the cart to R3's room, removed Systane eye drops from R3's medication cupboard and administered the eye drops. TMA then removed Gabapentin 100 mg from the locked drawer on the cart, signed Gabapentin out of the controlled medication book, locked the medication cart, obtained a glass of water and gave medications to R3. TMA returned the cart near the nurses station and went to the other hallway to a different medication cart. TMA removed artificial tears from R12's medication cupboard, entered R12's room, put on gloves and administered eye drops to R12. TMA removed gloves, locked R12's medication cupboard and signed out medication on the computer. TMA proceeded to R13's medication cupboard, removed one iron pill and gave to R13 sitting in the hall. TMA returned to the medication cart and sanitized hands. TMA pushed the medication cart to R9's room, took a plastic medication cup and wrote R9's name on it. TMA removed half a tab of Tramadol from the locked medication drawer, placed in medication cup, signed medication out of controlled medication book, removed Tylenol 500 mg two tabs from R9's medication cupboard, locked the cupboard and placed cup in the top drawer of the cart. TMA pushed the cart to R10's room, unlocked the medication cupboard, placed Tylenol 500 mg two tabs in a plastic medication cup, wrote R10's name on the cup and placed the cup in the top drawer of the cart next to the other cups. TMA pushed the cart to R11's room, unlocked medication cupboard, gave R11 Buspar 15 mg, Tylenol 500 mg (two tabs), Cosopt eye drops, proceeded to lock the cupboard and pushed the cart to the nurses station. TMA removed R9's and R10's cups from the top drawer of the cart, stacked the cups on top of each other and administered the medications to R10 in the dining room. TMA walked to the other dining room and gave R9 the other cup of medications that had her name on it. TMA returned to the cart, sanitized hands and signed medications out of the computer for R9 and R10. TMA walked to the other medication cart, unlocked the cart, removed a plastic cup from the top drawer with an unknown number of medications, locked the cart, brought the cup to the dining room and administered the medications to R5. During an interview on 9/11/24 at 2:16 p.m., TMA stated medications were to be administered according to the five rights; right resident, right medication, right route, right time, right dose and to confirm the medications against the computer orders. TMA stated she attempted to give the residents their medications while in their room however sometimes she did not see them until they were in the dining room and would bring the medications to them there. TMA verified the facility expectations were to sign out medications once given. TMA confirmed she prepared medications in advance and placed them in the top drawer of the medication cart. TMA stated sometimes a resident did not want the medications right away while they were eating or she would put the medications in the drawer of the medication cart until she knew where the resident was. During an interview on 9/11/24 at 2:05 p.m., registered nurse (RN) stated she checked medications three times against the computer orders and ensured the five rights of medication administration were followed before giving a resident medications. RN verified controlled medications were to be signed out of the book only after the resident had received the medication. RN confirmed the facility expectations were to prepare only one resident medications at a time to limit the chance of medication errors. During an interview on 9/11/24 at 2:38 p.m., facility pharmacy consultant (PC) verified the expectation was medications would be prepared and administered to a resident at that time and not prepared ahead of time. PC stated preparing medications ahead of time and administering them later increased the risk for a medication error. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245265	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Francis Home	2400 St Francis Drive Breckenridge, MN 56520

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/11/24 at 3:10 p.m., director of nursing (DON) verified expectations of staff were to prepare medications for residents one at a time to prevent medication errors. DON confirmed the facility policy stated medications were not to be prepared ahead of time. Review of the Skills: Medication Administration -General Guidelines policy undated, directed authorized staff to ensure medications were administered as prescribed in accordance with the five rights of medication administration. The policy indicated for staff to take steps to eliminate interruptions and distractions during medication preparation. The policy also directed staff to prepare medications for one patient at a time and to stay with the resident until the resident took each medication completely. Review of the Reconciliation of Controlled Substances policy revised 3/24, identified all controlled substances would be documented in the controlled substance ledger immediately after being administered to the resident.