| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245563 | A. Building<br>B. Wing | 01/28/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Green Pine Acres Nursing Home | 427 Main Street Northeast<br>Menahga, MN 56464 |

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 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to ensure medications were secured for 2 of 2 residents (R2, R4) observed unattended on the Transitional Care Unit (TCU). In addition, the facility failed to ensure safe refrigeration temperatures were maintained for 1 of 4 medication refrigerators (TCU Fridge C) reviewed for medication storage. This had the potential to affect residents residing on the TCU. Findings include:Medication Left Unattended:R2's significant change Minimum Data Set (MDS) dated [DATE], identified R2 was cognitively intact and had diagnoses including heart disease and diabetes. R2 received daily injections of insulin. R2's medication order report dated 1/28/26, identified Lantus SoloStar subcutaneous solution pen-injector 100 unit/ml (insulin glargine) inject 9 unit subcutaneously in the morning for DMII, order date 1/19/26.R4's admission MDS dated [DATE], identified R4 was cognitively intact and had diagnoses including renal insufficiency, and diabetes. R4 received daily insulin injections. R4's medication order report dated 1/28/26 identified Lantus SoloStar subcutaneous solution pen-injector 100 unit/ml (insulin glargine) inject 10 unit subcutaneously two times a day for DMII, order date 1/22/26.On 1/28/26 at 7:16 a.m., trained medication aide (TMA)-A was standing at a TCU medication cart prepping medication for a resident. The medication cart was against the wall next to the nurse's desk and in the same area as a larger common area used as the dining room. There were two residents seated at different tables in the area and no staff in the visible area near or around the medication cart. There were two labeled insulin Solostar pens on the corner of the medication cart belonging to R2 and R4. TMA-A was standing at the medication cart, facing the wall with her back to the dining area and prepped and picked up supplies to check a resident's blood sugar. TMA-A turned away from the medication cart, walked into the dining area. TMA-A followed the residents across the dining area, into their room and checked the residents' blood sugar. leaving the insulin back to the medication cart unattended. TMA-A was unable to observe the medications while in the resident's room and checking their blood sugar. Directly following the observation TMA-A stated she had set the insulin pens on the medication cart, just left them there and walked away while one other male resident was seated in the dining room. The risk of leaving insulin and/or medications on the cart was that someone else could pick up the medication and use it. TMA-A stated she should not have left the insulin pens unattended on the medication cart.On 1/28/26 at 7:26 a.m., licensed practical nurse, (LPN)-A walked to the medication cart and removed the two insulin pens from the cart. LPN-A stated there were residents that wheeled around the unit without staff assistance and the insulin pens should not have been left unattended on the cart. The risk of leaving medications unattended was that someone else could take the medications.On 1/28/26 at 8:02 a.m., registered nurse (RN)-A stated medications should not be left unattended on medication carts. The risk of leaving medications unattended was someone else picking them up and using them.The facility Medication Storage policy dated 2/22/24, included all drugs would be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) and during a medication pass, medications must be under the direct<br>(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 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | observation of the person administering medications or locked in the medication storage area/cart.Medication Refrigerator Temps:The TCU fridge temperature log dated Jan/[DATE], identified nine columns and four rows across the page. The form had instructions for the PM shift and NOC shift. They were to check the temperatures each day and document their initials and record the temperature in the box. At the end of the month staff were to place the form in the DON's box. Columns across the top identified a section labeled PM and NOC shift and one column for each day of the week, Monday through Sunday. Rows across the page identified week one through week four, and had two boxes (one for PM shift and one for NOC shift) for staff to document their initials and fridge temp. Instructions typed across the bottom of the page identified if temps were less than 36 degrees or greater than 46 degrees staff were to report to DON and maintenance and to keep the form in the narcotic book to ensure it was not forgotten as it was required. The form identified there were eight temperatures recorded that were less than the recommended 36-degrees along with six missed entries.The TCU medication room observation was completed on 1/28/26 at 8:08 a.m., with registered nurse (RN)-A. There were two unlocked refrigerators - one under the sink cabinet (C) and a smaller fridge on the floor (F). RN-A stated fridge temps are monitored twice daily, once on the evening shift and once on the night shift and staff were to document on the fridge temp log. At the end of the month the logs were sent to the DON. Fridge temps were to be maintained between 36- and 46-degrees Fahrenheit (F) and staff were instructed to contact maintenance if the temps were out of range. RN-A stated during the month of January 2026, there were five entries where fridge C was out of range, and six days and 12 occasions that the log was blank indicating the temp was not checked. Fridge C contained resident medications including Lantus insulin, NovoLog insulin, T-Dap, Prevnar, and COVID vaccines. On 1/28/26 at 9:50 a.m., the director of nursing (DON) stated staff on the units were supposed to check and document the fridge temps twice daily. At the end of the month the forms were sent to the DON. The DON stated she did not review the forms and assumed the unit managers reviewed the logs before sending them to her (the DON). The nursing staff were instructed to contact maintenance, as well as herself, if there were issues with the fridges. The DON stated she was unaware of any out-of-range temps for the TCU fridges for the month of January. DON reviewed the January 2026 fridge temp log and stated 5 entries were less than the recommended 36 degrees F and six days were left blank.On 1/28/26 at 11:49 a.m., the pharmacist stated the facility should check their fridge temps according to their policy and if the temps fell out of range, they should follow their policy as well as contact the pharmacist for review of medication recommendations regarding low/high temp exposure. The pharmacist stated he did not have any immediate concerns regarding the low temps although he would have to reach out to the facility and review an itemized list of the medications in the fridge and the recommendations to be sure.On 1/28/26 at 12:47 p.m., the DON stated RN-A had contacted the pharmacy earlier and discussed each of the medications in fridge C. The pharmacist recommended the following medications be destroyed and replaced:One Lantus Solostar penOne Novolog Solostar penOne Prevnar injectionOne T-Dap vaccineOne COVID vaccineThe facility Medication Fridge Policy dated 9/12/19 identified the medication fridge should be checked twice daily and the goal range was between 36- and 46-degrees F. Anything outside of range should be reported to the DON and maintenance. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to follow their policies, and or acceptable standards of practice, to ensure medication administration accuracy for 2 of 2 residents (R23, R66) reviewed for narcotic count accuracy. Findings include:R23's comprehensive Minimum Data Set (MDS) dated [DATE], identified R23 was cognitively aware and had diagnoses that included breast cancer, heart failure, and chronic obstructive pulmonary disease (COPD). R23 was receiving hospice services. R23's physician order dated 12/5/25, identified lorazepam oral tablet 0.5 milligram (mg). Give 1 tablet by mouth every 4 hours as needed for anxiety/agitation for 14 Days. Call Hospice prior to administering the first dose - must chart non-pharmacological interventions attempted.R23's Medication Administration Record dated December 2025, identified lorazepam oral tablet 0.5 milligram (mg). Give 1 tablet by mouth every 4 hours as needed for anxiety/agitation for 14 Days. Call Hospice prior to administering the first dose - must chart non-pharmacological interventions attempted. However, the record did not identify R23 ever received the medication.The undated black, bound Individual Narcotic Record identified on page 97 R23's lorazepam was received on 12/5/25 with an RX number (a unique identifier assigned to a prescription) of 4004867 518 with five 0.5 milligram (mg) tablets received. On 12/29/25, a handwritten entry identified two tablets were administered to R23 by trained medication aide (TMA)-B, however, this line was scratched out and underneath the quantity remaining identified 5 along with licensed practical nurse (LPN)-B's signature. A sticky paper was attached to the page with a handwritten note that stated, 5 different tabs/code 1/2 tabs are 0.5 mg [NAME] RN.During an observation on 1/26/26 at 6:11 p.m., R23's lorazepam bottle held three 0.5 mg tablets of lorazepam and a 1 mg tablet of lorazepam broken into two pieces totaling five 0.5 mg tablets.R66's undated admission Record, identified R66 was admitted to the facility on [DATE] and had diagnosis that included cancer and palliative care.R66's Order Summary Report dated 12/12/25, identified lorazepam oral tablet 1 mg tablets. Give 1 tablet by mouth four times a day for anxiety/shortness of breath (SOB). - every 6 hours around the clock (ATC).R66's Medication Administration Record dated December 2025, identified R66 received lorazepam 1 mg on 12/29/25 at 7:00 p.m.The undated black, bound Individual Narcotic Record identified on page 126 R66's lorazepam was received on 1211/25 with an RX number (a unique identifier assigned to a prescription) of 4005034. On 12/29/25 at 6:48 p.m., a handwritten entry identified 1 tablet were administered to R66 by TMA-B.During an interview on 1/26/26 at 7:11 p.m., LPN-B stated she was aware of a discrepancy with R66 and R23's lorazepam narcotic count, but it had been a long time since that happened and didn't recall the date nor what occurred. LPN-B did recall replacing the tablets in R23's lorazepam prescription bottle because they're the same strength even though it was a 1 mg tablet broken in half. LPN-B stated no staff were directed to not take from one medication bottle and put in another, but R23's medication was mistakenly used for R66. So, they were just replaced. LPN-B stated TMA-B had mistakenly used R23's medication for R66 and LPN-B only fixed it. During an interview on 1/26/26 at 7:14 p.m., TMA-B stated on 12/29/25 he mistakenly administered R23's lorazepam tablets to R66. TMA-B stated he realized his error as soon as he documented the administration on page 97 under R23. TMA-B stated he immediately brought the error to LPN-B. TMA-B nor LPN-B completed a medication error report nor reported the error to administration.During an interview on 1/26/26 at 7:27 p.m., LPN-B stated the incident was a medication error because the medication was administered to the wrong resident and the tablet dose did not match the medication order. LPN-B stated TMA-B should have realized it was the incorrect medication when comparing the bottle to the medication order. LPN-B stated she did not inform administration because LPN-B replaced the medication in the bottle and thought it wasn't a big deal. During a telephone interview on 1/27/26 at 9:34 a.m., the pharmacist stated he was unaware of a medication error involving R23 and R66's lorazepam and<br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | stated the facility must complete a medication error report. Stated staff were not allowed to borrow medications between residents for medication safety and for tracking of medications. Education would be provided to the staff to ensure all staff were aware of the process and what to do in the future. During an interview on 1/28/26 at 11:39 a.m., registered nurse (RN)-A stated when a discrepancy or incorrect medication was used in error a medication error report was completed. The report was a paper form and once completed was given to RN-A. RN-A would do an investigation of what happened and then provide education to the staff involved. After that, the form would be given to the director of nursing (DON). RN-B stated she was unaware of error when R23's lorazepam was used until 1/27/25. Afterwards, the pharmacist was contacted to get his recommendations. RN-A stated LPN-B completed a medication error report on 1/27/25. Staff had been told not to borrow medications from residents to use for another and to notify pharmacy, the RN in charge, and the resident's provider.During an interview on 1/28/26 at 11:55 a.m., the DON stated she was notified of the medication error on 12/27/25 when the person involved came forward and wrote herself up. When a staff member makes a medication error, they complete a medication error report and give it to the unit manager or the DON. Then, either the unit manager or the DON, provide one-to-one education to the staff member and then do an audit to ensure further education did not need to occur. The DON stated when LPN-B explained the situation, LPN-B didn't realize replacing the medication was wrong. LPN-B thought it was an easy fix, and she had been educated on how the process should have been. Normally, the DON would expect staff to report it as a medication error. The DON stated there were a couple reasons why staff could not borrow from one resident's medications for another resident. First, the pharmacist dispenses medications and there is a process to ensure medications were correct and it was best practice in having more than one person involved to ensure safety. Additionally, there was the financial piece as well because the medication belongs to the resident. Further, it was best practice to be aware of the error because LPN-B had never incurred a situation like that and just didn't realize it was an error. All staff could learn from that. During an interview on 1/28/26 at 2:21 p.m., the administrator stated she expected staff to inform the DON of all medication errors when identified and to follow facility policy. The facility policy Medication Administration revised 5/22/24, identified the six {6) rights of medication administration should be followed with each medication or treatment. These include right resident, medication, dose, time, route, and documentation.A facility policy regarding medication error was requested but not received. |