Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL366913924M
Compliance #: HL366916548C

Date Concluded: March 14, 2023

Name, Address, and County of Licensee Investigated:

Generations Home Care, Inc.
841 Pinecone Road
Sartell, MN 56377
Stearns County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Jill Hagen, RN,
Special Investigator

Finding: Substantiated, individual responsibility

Nature of Visit:
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 alleged perpetrator (AP), unlicensed facility staff, financially exploited a resident when the AP purchased a vehicle from the resident. In addition, the AP refused to pay the resident for the mutually agreed upon purchase price for the vehicle.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. The AP purchased a vehicle from the resident and then refused to pay the agreed upon amount for the vehicle.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement. The investigation included review of the resident's medical record, purchase agreement for a vehicle between the resident and AP, facility policy and procedures, and the AP's personnel file.

The resident resided in an assisted living facility with diagnoses including major depression, anxiety, and personality B disorder (an inappropriate, emotional, and often unpredictable response to situations). The resident's service plan included staff assistance with medication administration, safety checks every two hours, meal preparation, laundry, and housekeeping. The resident's assessment indicated the resident was not at risk for abuse by others and was his own decision-maker.

The facility investigation indicated the AP signed a "homemade" contract with the resident to purchase the resident's vehicle "as is" for a total of $2500.00. The agreement indicated the AP would pay $1500.00 as the initial deposit, and then pay the resident $200.00 biweekly ($400.00) every month for the next two and one-half months for a total of $1000.00 (or the total agreed purchase amount of $2500.00). The AP made the initial down payment of $1500.00, two payments of $200.00, which left a balance owed to the resident of $600.00. The resident attempted multiple times to reach out to the AP for payments, but the AP refused to return the residents calls.

Review of text messages between the AP and resident indicated the AP agreed she owed the resident the additional money but continued to extend the date of payment. On one text, the AP stated she did not have the money for the car, so the resident asked the AP to return the car. The AP responded "The car is already in my name, it's mine. You'll have to take me to court, and you don't have any real documents stating the sale at all. If you can't be patient and wait until I have the money, I don't care about going to court. The car is mines [sic] and you're not getting it back." The resident responded, "All I want is my money so I can pay my rent."

The text messages extended over five months past the original sale and agreed upon date of the final payment of the vehicle. The last text message from the resident to the AP occurred seven months after the agreement to purchase the vehicle. The resident text the AP, "I'm getting in touch with you about the rest of the money you still need to pay. I would like to get this deal over and done with ok. Please contact me at your earliest convenience."

Review of the facility's messages between the AP and facility management indicated the AP requested approval from management to purchase the resident's vehicle. Management responded to the AP, "because of the nature and protection required of the vulnerable adult and employee relationship, business between staff (residents) was not allowed." A second text from management to the AP indicated, "even if you quit, it would be borderline financial exploitation because the (resident) was a vulnerable adult. Minnesota law stated that employees (past or present) should not acquire possessions, control, or have an interest in funds or property of a vulnerable adult…"

During an interview, management stated the AP made the agreement to purchase the resident's vehicle without facility knowledge. Management stated when the AP stopped paying the resident for the vehicle, the resident reported the sale of the vehicle to the AP.

Management stated the AP received training regarding the vulnerable adult act including financial exploitation and the definition of a vulnerable adult.

During an interview, the AP stated she was aware she was the resident's caregiver and should not be purchasing the resident's vehicle. The AP stated she owed the resident $600.00 for the purchase of the resident's vehicle but had not been able to afford to pay it.

In conclusion, the Minnesota Department of Health determined financial exploitation was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Financial exploitation: Minnesota Statutes, section 626.5572, subdivision 9
"Financial exploitation" means:
(b) In the absence of legal authority, a person:
(1) willfully uses, withholds, or disposes of funds or property of a vulnerable adult;
(2) obtains for the actor or another the performance of services by a third person for the wrongful profit or advantage of the actor or another to the detriment of the vulnerable adult;
(3) acquires possession or control of, or an interest in, funds or property of a vulnerable adult through the use of undue influence, harassment, duress, deception, or fraud; or
(4) forces, compels, coerces, or entices a vulnerable adult against the vulnerable adult's will to perform services for the profit or advantage of another.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: VA was own responsible party.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The AP is no longer employed by the facility.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment.

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

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:

The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Stearns County Attorney
Sartell City Attorney
Sartell Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36691	A. BUILDING: _____ B. WING _____	C 02/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENERATIONS HOME CARE INC	841 PINECONE ROAD SARTELL, MN 56377

(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
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING 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: #HL366916548C/#HL366913924M On February 15, 2023, the Minnesota Department of Health initiated a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were six residents receiving services under the provider's Assisted Living license. The following correction orders are issued for HL366916548C/#HL366913924M, tag identification 0620, 1290, 2360, and 3000.	0 000	Minnesota Department of Health is documenting the State Licensing 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.	
0 620 SS=D	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36691	A. BUILDING: _____ B. WING _____	C 02/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENERATIONS HOME CARE INC	841 PINECONE ROAD SARTELL, MN 56377

(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
0 620	Continued From page 1 (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed implement their policy to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment of one of one (R1) residents reviewed for maltreatment. R1 reported to staff unlicensed personnel (ULP)-B financially exploited R1 when ULP-B purchased a vehicle from R1 and refused to pay R1 the agreed amount for the vehicle. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause 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). Findings include: R1 was admitted to the assisted living facility on February 8, 2022, with diagnoses including major depression, anxiety, cluster B personality (an inappropriate, emotional, and often unpredictable response to situations), and chronic pain. R1's plan of care dated February 11, 2022, indicated R1 received services from the licensee	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36691	A. BUILDING: _____ B. WING _____	C 02/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENERATIONS HOME CARE INC	841 PINECONE ROAD SARTELL, MN 56377

(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
0 620	Continued From page 2 with reminders for grooming and bathing, and staff assistance with medication administration, every two hour safety checks, meal preparation, and housekeeping. A typed note signed by ULP-B on June 9, 2022, indicated R1 sold his vehicle to ULP-B for $2500.00. ULP-B agreed to pay R1 $1500.00 in June 2022, and $200.00 every other week ($400.00 a month) for the next 2-1/2 months, with the last payment due on September 15, 2022. Review of text messages between the licensee's licensed assisted living director (LALD) and ULP-B dated June 9, 2022, indicated the LALD became aware that R1 sold his vehicle to ULP-B. Review of a text message between the licensee supervisor and the LALD dated August 26, 2022, indicated both staff were aware ULP-B failed to pay R1 the remainder of the money owed to R1. Review of a text message initiated by the LALD to ULP-B dated September 22, 2022, at 10:58 a.m. stated, "This is about the money that is still owed to the vulnerable adult (R1). I previously warned you that any financial transactions between you and (R1) were not allowed due to (R1) being classified as a vulnerable adult...You need to pay him or I will have to report that his (R1)'s finances have been abused." A Minnesota Adult Abuse Report form was submitted to the state agency by the LALD on November 28, 2022. The report was made approximately six months after the licensee became aware of the vehicle agreement between ULP-B and R1, and approximately three months after the licensee became aware of ULP-B refusal to pay R1. The report indicated ULP-B	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36691	A. BUILDING: _____ B. WING _____	C 02/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENERATIONS HOME CARE INC	841 PINECONE ROAD SARTELL, MN 56377

(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
0 620	Continued From page 3 made payments to R1 for the vehicle until August 15, 2022. ULP-B owed the remainder $600.00 to R1. R1 made numerous attempts to reach ULP-B by phone and to arrange the payments. ULP-B did not return R1's calls or make any payments since July 31, 2022. During an interview on February 23, 2023, at 1:29 p.m. ULP-B stated the LALD told her as an employee, ULP-B should not purchase the vehicle from R1. ULP-B stated the licensee should have reported her sooner to the state agency. During an interview on February 27, 2023, at 11:02 a.m. the LALD stated they did not report the financial exploitation of R1 until the end of November when another employee told the LALD they were reporting the incident between R1 and ULP-B for financial exploitation. Review of the licensee's policy and procedure titled Vulnerable Adult Maltreatment-Prevention and Reporting with an effective date of August 1, 2021, indicated, "Maltreatment is defined as neglect, abuse, and financial exploitation...Staff who suspect maltreatment of a resident (abuse, financial exploitation, neglect)...will contact the Assisted Living Director. If the Assisted Living Director or Clinical Nurse Supervisor confirms the suspicion of maltreatment, they will contact the Minnesota Adult Abuse Report Center...Such report must be made no later than 24 hours after the maltreatment was first suspected..." TIME PERIOD FOR CORRECTION: Seven (7) Days	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36691	A. BUILDING: _____ B. WING _____	C 02/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENERATIONS HOME CARE INC	841 PINECONE ROAD SARTELL, MN 56377

(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
01290	Continued From page 4	01290		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to provide direct and continuous supervision as directed by the employees background study for one of one unlicensed personnel (ULP-B) investigated for maltreatment. This failure had the ability to affect all six residents at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include:	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36691	A. BUILDING: _____ B. WING _____	C 02/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENERATIONS HOME CARE INC	841 PINECONE ROAD SARTELL, MN 56377

(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
01290	Continued From page 5 ULP-B's personnel file indicated she was hired on May 15, 2022, to provide direct care services to residents. The Minnesota Department of Human Services letter to the licensee dated June 23, 2022, indicated the background study unit received information and ULP-B was disqualified from any position with direct contact or access to individuals receiving services from all entities under the licensees organization. The background Studies Division determined ULP-B "posed a risk of harm." The letter indicated ULP-B could provide direct contact services only with continuous and direct supervision pending a possible reconsideration decision. The Minnesota Department of Human Services letter to the licensee dated August 10, 2022, indicated ULP-B requested a reconsideration of the disqualification decision on August 8, 2022. The licensee failed to provide additional information regarding ULP-B's disqualification. Review of the licensee staff schedules from May 16, 2022, through October 9, 2022, indicated ULP-B was scheduled to provide direct care without continuous and direct supervision the following days: May 16, 2022, through May 31, 2022. Six of six shifts. June 1, 2022, through June 30, 20022. 19 of 19 shifts. July 1, 2022, through July 31, 2022. 15 of 17 shifts.	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36691	A. BUILDING: _____ B. WING _____	C 02/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENERATIONS HOME CARE INC	841 PINECONE ROAD SARTELL, MN 56377

(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
01290	Continued From page 6 August 1, 2022, through August 31, 2022. 12 of 14 shifts. September 1, 2022, through September 28, 2022. Three of three shifts. The staff schedule for September 2022, indicated ULP-B's last scheduled shift for the licensee was September 28, 2022. During an interview, licensed assisted living director (LALD)-A stated the facility supervisor provided the necessary supervision for staff when needed. LALD-A stated ULP-B worked many times without the supervisors direct and continuous supervision. Review of the licensee's policy and procedure titled Background Studies with an effective date of August 1, 2021, indicated, "No employee may provide direct services and have independent direct contact with any residents until acceptable result [sic] have been received...Procedure...the licensee will initiate a background study on all employees being considered for hire. If hired prior to receiving the background study or the tentative background study results indicate more time is needed requiring supervision, new hires shall not be permitted to interact or provided services...except under the direct supervision (eyesight) of another qualified staff person." TIME PERIOD FOR CORRECTION: Seven (7) days.	01290		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial	02360		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36691	A. BUILDING: _____ B. WING _____	C 02/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENERATIONS HOME CARE INC	841 PINECONE ROAD SARTELL, MN 56377

(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
02360	Continued From page 7 exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one residents reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the Alleged Perpetrator (AP) was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details. No plan of correction is required for this tag. Please refer to the public maltreatment report for details.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	
03000 SS=D	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36691	A. BUILDING: _____ B. WING _____	C 02/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENERATIONS HOME CARE INC	841 PINECONE ROAD SARTELL, MN 56377

(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
03000	Continued From page 8 (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment of one of one (R1) residents reviewed for maltreatment. R1	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36691	A. BUILDING: _____ B. WING _____	C 02/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENERATIONS HOME CARE INC	841 PINECONE ROAD SARTELL, MN 56377

(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
03000	Continued From page 9 reported to staff that unlicensed personnel (ULP)-B financially exploited R1 when ULP-B purchased a vehicle from R1 and refused to pay for the entire agreed upon amount of the vehicle. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause 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). Findings include: R1 was admitted to the assisted living facility on February 8, 2022, with diagnoses including major depression, anxiety, cluster B personality (an inappropriate, emotional, and often unpredictable response to situations), and chronic pain. R1's plan of care dated February 11, 2022, indicated R1 received services from the licensee with reminders for grooming and bathing, and staff assistance with medication administration, every two hour safety checks, meal preparation, and housekeeping. A typed note signed by ULP-B on June 9, 2022, indicated R1 sold his vehicle to ULP-B for $2500.00. ULP-B agreed to pay R1 $1500.00 in June 2022, and $200.00 every other week ($400.00 a month) for the next 2-1/2 months, with the last payment due on September 15, 2022. Review of text messages between the licensee's licensed assisted living director (LALD) and ULP-B dated June 9, 2022, indicated the LALD	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36691	A. BUILDING: _____ B. WING _____	C 02/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENERATIONS HOME CARE INC	841 PINECONE ROAD SARTELL, MN 56377

(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
03000	Continued From page 10 became aware that R1 sold his vehicle to ULP-B. Review of a text message between the licensee supervisor and the LALD dated August 26, 2022, indicated both staff were aware ULP-B failed to pay R1 the remainder of the money owed to R1. Review of a text message initiated by the LALD to ULP-B dated September 22, 2022, at 10:58 a.m. stated, "This is about the money that is still owed to the vulnerable adult (R1). I previously warned you that any financial transactions between you and (R1) were not allowed due to (R1) being classified as a vulnerable adult...You need to pay him or I will have to report that his (R1)'s finances have been abused." A Minnesota Adult Abuse Report form was submitted to the state agency by the LALD on November 28, 2022. The report was made approximately six months after the licensee became aware of the vehicle agreement between ULP-B and R1, and approximately three months after the licensee became aware of ULP-B refusal to pay R1. The report indicated ULP-B made payments to R1 for the vehicle until August 15, 2022. ULP-B owed the remainder $600.00 to R1. R1 made numerous attempts to reach ULP-B by phone and to arrange the payments. ULP-B did not return R1's calls or make any payments since July 31, 2022. During an interview on February 23, 2023, at 1:29 p.m. ULP-B stated the LALD told her as an employee, ULP-B should not purchase the vehicle from R1. ULP-B stated the licensee should have reported her sooner to the state agency. During an interview on February 27, 2023, at	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36691	A. BUILDING: _____ B. WING _____	C 02/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENERATIONS HOME CARE INC	841 PINECONE ROAD SARTELL, MN 56377

(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
03000	Continued From page 11 11:02 a.m. the LALD stated they did not report the financial exploitation of R1 until the end of November when another employee told the LALD they were reporting the incident between R1 and ULP-B for financial exploitation. Review of the licensee's policy and procedure titled Vulnerable Adult Maltreatment-Prevention and Reporting with an effective date of August 1, 2021, indicated, "Maltreatment is defined as neglect, abuse, and financial exploitation...Staff who suspect maltreatment of a resident (abuse, financial exploitation, neglect)...will contact the Assisted Living Director. If the Assisted Living Director or Clinical Nurse Supervisor confirms the suspicion of maltreatment, they will contact the Minnesota Adult Abuse Report Center...Such report must be made no later than 24 hours after the maltreatment was first suspected..." TIME PERIOD FOR CORRECTION: Seven (7) Days	03000		