DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: BURF

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00634

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245339**

2.STATE VENDOR OR MEDICAID NO.
(L2) **222043100**

3. NAME AND ADDRESS OF FACILITY
(L3) **MOTHER OF MERCY SENIOR LIVING**
(L4) **230 CHURCH AVENUE, BOX 676**
(L5) **ALBANY, MN** (L6) **56307**

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/21/2017** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **73** (L18)

13.Total Certified Beds **73** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	73			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
Annette Truebenbach, HFE NE II — 09/21/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 10/31/2017 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
07/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 11/08/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/14/2017
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 31, 2017

Mr. Dean McDevitt, Administrator
Mother Of Mercy Senior Living
230 Church Avenue, Box 676
Albany, MN 56307

RE: Project Number S5339026 & H5339014

Dear Mr. McDevitt:

On August 11, 2017, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective August 16, 2017. (42 CFR 488.422)

In addition this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region IV Office that the following enforcement remedy be imposed:

- Civil Money Penalty for the deficiency cited at F323 (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for a standard survey completed on July 28, 2017. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On September 21, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on September 12, 2017, the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 28, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 5, 2017. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 28, 2017, as of September 5, 2017.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective September 5, 2017.

In addition, this Department recommended to the CMS Region V Office the following action related to the recommended remedy outlined in our letter of August 11, 2017:

- Per instance civil money penalty for the deficiency cited at F323 be imposed. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245339 October 31, 2017

Mr. Dean McDevitt, Administrator
Mother Of Mercy Senior Living
230 Church Avenue, Box 676
Albany, MN 56307

Dear Mr. McDevitt:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective September 5, 2017 the above facility is certified for or recommended for:

73 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 73 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: BURF

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00634

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245339**

2.STATE VENDOR OR MEDICAID NO.
(L2) **222043100**

3. NAME AND ADDRESS OF FACILITY
(L3) **MOTHER OF MERCY SENIOR LIVING**
(L4) **230 CHURCH AVENUE, BOX 676**
(L5) **ALBANY, MN** (L6) **56307**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/28/2017** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **73** (L18)

13.Total Certified Beds **73** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	73			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
Annette Truebenbach, HFE NE II 08/22/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 09/14/2017 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
07/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 09/15/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/14/2017
(L33)

DETERMINATION APPROVAL

Electronically delivered
August 11, 2017

Mr. Dean McDevitt, Administrator
Mother of Mercy Senior Living
230 Church Avenue, Box 676
Albany, MN 56307

RE: Project Number S5339026 & H5339014

Dear Mr. McDevitt:

On July 28, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the July 28, 2017 standard survey the Minnesota Department of Health completed an investigation of complaint number H5339014. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically submitted CMS-2567, whereby significant corrections are required.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Potential Consequences - the consequences of not attaining substantial compliance 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Kathleen Lucas, Unit Supervisor
St. Cloud B Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: kathleen.lucas@state.mn.us
Phone: (320) 223-7343
Fax: (320) 223-7348

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

For all surveys completed after September 1, 2016, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when one or more of the following circumstances exist:

- Immediate jeopardy (IJ) (scope and severity levels J, K, and L) is identified on the current survey; OR
- Deficiencies of Substandard Quality of Care (SQC) that are not IJ are identified on the current survey; OR
- Any G level deficiency is identified on the current survey in 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25 Quality of Care; OR
- Deficiencies of actual harm or above (level G or above) on the current survey as well as having deficiencies of actual harm or above on the previous standard health or Life Safety Code (LSC) survey OR deficiencies of actual harm or above on any type of survey between the current survey and the last standard survey. These surveys must be separated by a period of compliance (i.e., from different noncompliance cycles).; OR
- A facility is classified as a Special Focus Facility (SFF) AND has a deficiency citation at level "F" or higher on its current health survey or "G" or higher for the current LSC survey.

Note: the "current" survey is whatever Health and/or LSC survey is currently being performed, i.e., standard, revisit, or complaint.

Your facility meets one or more criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

- State Monitoring effective August 16, 2017. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedy be imposed:

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by October 28, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 28, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:
http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

DEPARTMENT OF HEALTH

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	**230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307**

(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) COMPLETION DATE
F 000	INITIAL COMMENTS On 7/24/17 to 7/28/17, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH). Mother of Mercy was found to not be in compliance with the regulations at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance. In addition, an investigation of complaint H5339014 was completed and found to be substantiated. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or	F 225		9/5/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 08/17/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 225	Continued From page 1 misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect,	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 225	Continued From page 2 exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure potential neglect with a significant injury was reported to the state agency within 2 hours for 1 of 6 (R84) residents reviewed for maltreatment. Findings include: R84's admission Minimum Data Set (MDS) assessment, dated 2/13/17, indicated R84 was totally dependent and required assistance 2+ person physical assist for transfers. The Care Area Assessment (CAA), dated 2/14/17, indicated R84 had a diagnoses, which included multiple sclerosis with quadriplegia. R84 was completely dependent for activities of daily living and mobility. R84 transferred with the assistance of two staff and an EZ lift for all transfers. R84's 5/16/17 quarterly MDS indicated moderate cognitive impairment. R84's care plan, last review date of 7/25/17, indicated R84 required assistance of 2 staff and an EZ lift for all transfers. The care plan indicated R84 had a witnessed fall on 7/6/17. On 7/7/17 an intervention to make sure the EZ lift sling was double looped at all times was added to R84's	F 225	a.)No ill effects to resident related to timing of self report to resident R84. b.) All residents are subject to a possible self-report not being submitted timely,but there have been no further untimely self reports c.)The facility policy and procedure on investigations has been updated to include the two hour and 24 hour time frame for reporting. DON, and nurse managers have reviewed the policy with changes.DON discussed with managers that any calls regarding anything reportable will be called immediately to DON and Administrator. Either DON or a Nurse Manager are on-call at all times. d.) The timeliness of all reports will be discussed at QAPI bi-monthly e.)Corrective action completed 8/4/2017 Administrator will be responsible for on going compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 225	Continued From page 3	F 225		

care plan.

An Event Report, dated 7/6/17 indicated R84 fell from an EZ lift during a transfer from the bed to a wheelchair around 3:45 p.m. on 7/6/17. Two nursing assistants (unidentified) assisted with the transfer. While one nursing assistant assisted R84's feet/legs off the bed, a second nursing assistant maneuvered the lift. As soon as R84's feet were off of the bed, the sling loop ripped. R84 fell to the floor, hitting his head/upper body first. Several nurses responded to assess R84. R84 was bleeding from the back of the head. R84 complained of pain to the back of the head, rating the pain 5 out of 10. Staff called for emergent transportation around 4:00 p.m., Emergency services arrived around 4:10 p.m. and was transported to the hospital at 4:14 p.m.

Hospital documentation, dated 7/6/17, revealed R84 had head trauma after falling 4 feet from a lift. R84 reported pain to the back of the head. R84 had two curved lacerations measuring approximately 2.0 inches each in length on the left occipital (back of head) region and a subcutaneous hematoma (bruise) to the left parietal occipital region. The left lateral laceration was repaired with Dermabond (skin glue.) The right laceration was closed with 11 sutures.

A progress note dated 7/6/17, indicated R84 returned to the facility the same day at 9:45 p.m.

The facility's fall investigation, dated 7/12/17, indicated the incident was not reported to the state agency until the following day, 7/7/17, at 10:15 a.m. After the fall, representative (rep)-D from the EZ way lift company came to the facility and inspected all the lift slings and stand

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 225	Continued From page 4 harnesses with the DON. "It has been policy that both laundry and nursing staff inspect slings for any fraying or other problems. This policy has been followed." Policy changed so all lift transfers will be double looped. During an interview on 7/27/17, at 12:43 p.m. with the DON and administrator. The DON stated the incident was not immediately reported as she wanted to know the extent of R84's injuries. "I didn't think it was a serious injury." "I thought it was a moderate injury." The administrator stated they had 24 hours to report as there was no fracture and R84 was totally alert. The facility's policy Abuse Prevention and Vulnerable Adult Procedure, dated 7/15, indicated neglect as the "Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." The policy indicated the supervisor will immediately report all suspected maltreatment to the administrator and DON or RN on call and to other officials in accordance with state and federal law.	F 225		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and	F 226		9/5/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 226	Continued From page 5 (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure potential neglect with a significant injury was reported to the state agency according to their policy for 1 of 6 (R84) residents reviewed for maltreatment. Findings include: The facility's policy Abuse Prevention and Vulnerable Adult Procedure, dated 7/15, indicated neglect as the "Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." The policy indicated the supervisor will immediately report all suspected maltreatment to the administrator and DON or RN on call and to other officials in	F 226	a.)There were no ill effects to resident R84 related to untimely self report, the report was sent within 24 hours, but not within the required 2 hour time frame. b.)All residents are subject to untimely reporting of self-reports. There have not been any untimely self -reports since that report c.)The facility policy and procedure on investigations has been updated to include the two hour and 24 hour time frame for reporting. Administrator, DON and nurse managers have reviewed the policy with changes.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 226	Continued From page 6 accordance with state and federal law. R84's admission Minimum Data Set (MDS) assessment, dated 2/13/17, indicated R84 was totally dependent and required assistance 2+ person physical assist for transfers. The Care Area Assessment (CAA), dated 2/14/17, indicated R84 had a diagnoses, which included multiple sclerosis with quadriplegia. R84 was completely dependent for activities of daily living and mobility. R84 transferred with the assistance of two staff and an EZ lift for all transfers. R84's 5/16/17 quarterly MDS indicated moderate cognitive impairment. R84's care plan, last review date of 7/25/17, indicated R84 required assistance of 2 staff and an EZ lift for all transfers. The care plan indicated R84 had a witnessed fall on 7/6/17. On 7/7/17 an intervention to make sure the EZ lift sling was double looped at all times was added to R84's care plan. An Event Report, dated 7/6/17, indicated R84 fell from an EZ lift during a transfer from the bed to a wheelchair around 3:45 p.m. on 7/6/17. Two nursing assistants (unidentified) assisted with the transfer. While one nursing assistant assisted R84's feet/legs off the bed, a second nursing assistant maneuvered the lift. As soon as R84's feet were off of the bed, the sling loop ripped. R84 fell to the floor, hitting his head/upper body first. Several nurses responded to assess R84. R84 was bleeding from the back of the head. R84 complained of pain to the back of the head, rating the pain 5 out of 10. Staff called for emergent transportation around 4:00 p.m., Emergency services arrived around 4:10 p.m. and was transported to the hospital at 4:14 p.m.	F 226	DON discussed with Nurse managers that any reportable incident must be reported to the DON and Administrator immediately. The DON or a Nurse manager is always on-call. d.)The reporting compliance will be discussed at QAPI bi-monthly to assure continued compliance Administrator will be responsible for on going compliance. e.)Correction date 08/04/2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 226	Continued From page 7 Hospital documentation, dated 7/6/17, revealed R84 had head trauma after falling 4 feet from a lift. R84 reported pain to the back of the head. R84 had two curved lacerations measuring approximately 2.0 inches each in length on the left occipital (back of head) region and a subcutaneous hematoma (bruise) to the left parietal occipital region. The left lateral laceration was repaired with Dermabond (skin glue.) The right laceration was closed with 11 sutures. A 7/6/17 progress note, indicated R84 returned to the facility the same day at 9:45 p.m. The facility's fall investigation, dated 7/12/17, indicated the incident was not reported to the state agency until the following day, 7/7/17, at 10:15 a.m. After the fall, representative (rep)-D from the EZ way lift company came to the facility and inspected all the lift slings and stand harnesses with the DON. "It has been policy that both laundry and nursing staff inspect slings for any fraying or other problems. This policy has been followed." Policy changed so all lift transfers will be double looped. During an interview on 7/27/17 at 12:43 p.m. with the DON and administrator. The DON stated the incident was not immediately reported as she wanted to know the extent of R84's injuries. "I didn't think it was a serious injury." "I thought it was a moderate injury." The administrator stated they had 24 hours to report as there was no fracture and R84 was totally alert.	F 226		
F 246 SS=D	483.10(e)(3) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES	F 246		9/5/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 246	Continued From page 8 483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: (e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide accommodations for communication after hearing aids went missing for 1 of 1 resident (R50) reviewed for social services. Findings include: R50's Diagnoses Report dated 7/28/17, included diagnoses of dementia, Alzheimer's disease, major depressive disorder, and anxiety disorder. R50's annual Minimum Data Set (MDS) dated 3/8/17, indicated R50 had severe cognitive impairment, had adequate vision, used hearing aids, and had moderate difficulty hearing with hearing aids present. The MDS indicated activities that were very important to R50 included; listening to music she liked and participating in her favorite activities and religious services, and it was somewhat important to her do things with groups of people. R50's communication Care Area Assessment (CAA) was located in an annual review nursing progress note dated 3/13/17 (requested and not received). The review note indicated R50 had	F 246	a) Resident 50 had lost hearing aids and was unable to properly hear staff in activities or during cares. Care plan revision was done. b) All residents would be considered at risk if care plan updating were not done related to change in condition. c) Care plan revision was completed on 08/07/2017 to include special approaches in order that resident will have better understanding of activities and better understanding of staff during cares, meals/etc. At morning clinical meeting, any condition changes are discussed on all residents. RN manager will be responsible for any needed care plan updates and will confirm at afternoon clinical meeting with DON or designee that this has been completed. Care plans are reviewed quarterly and with any condition changes, and will be assessed for current condition of resident. This will be completed on or before 08/31/2017 and ongoing. An in-service with all nurses, in regards to missing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 246	Continued From page 9 minimal difficulty hearing with hearing aids in both ears, had difficulty finding words, and finishing thoughts at times related to dementia, was usually able to understand information communicated to her, and had some difficulty processing information. The review note also included that R50 continued to attend activities of interest and did many independent activities in her room. R50's quarterly MDS dated 6/6/17, indicated R50 did not have hearing aids and the speaker had to increase volume and speak distinctly. A quarterly review progress note dated 6/7/17 indicated R50 used hearing aids for both ears however, the hearing aids were missing, and the facility was working to replace them. The note also included R50 continued to attend activities of interest and did many independent activities in her room, however, R50's care plan was not revised to reflect the missing hearing aids, and did not include interventions that would accommodate the increased hearing loss related to the missing hearing aids. R50's communication care plan dated 3/8/16 indicated R50 had hearing impairment, utilized hearing aids for both ears which enhanced her hearing, R50 was able to hear adequately with the use of the aids, and usually able to make herself understood and she usually understood others. The care plan directed staff to provide a quiet non-hurried environment free of background noises and distraction, assist R50 with placing hearing aids in the morning, and speak into ear with hearing aid present for better hearing. The care plan also directed to repeat/rephrase as necessary, and allow adequate time for R50 to finish and communicate thoughts.	F 246	items and the process of filling out a grievance form and accommodations for residents with difficulty hearing, immobility, etc. to take place on or before September 7th, 2017. DON will report to QAPI regarding outcomes from above strategy and reviewed if needed. Corrective action to be completed on or before 09/05/2017. DON is responsible.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 246	Continued From page 10	F 246		

R50's activity care plan dated 3/4/16, informed staff R50 required some assistance to pursue leisure activities due to cognitive deficits. The care plan directed staff to guide R50 to group activities of interest which included; special events, music programs, crafts, bingo, children's groups, and spiritual programs. The care plan indicated when R50 was not in a group activity her likes included visiting with people and watching TV. The care plan also directed staff to provide cues and hands on assistance as needed.

R50's treatment administration record (TAR) directed staff to remove both hearing aids in the morning and take them out in the evening. The TAR reflected on 5/20/17, at 7:54 p.m. both hearing aids were missing.

During observation on 7/24/17, at 11:41 a.m. R50 did not have hearing aids in her ears. During conversation with R50, surveyor had to speak loudly and directly into either of R50's ears and frequently had to repeat and or rephrase statements and questions. When R50 could hear surveyor, answers or responses were appropriate.

During an interview on 7/25/17, at 1:52 p.m. R50's family member (FA)-A stated both R50's hearing aids went missing more than a month ago and was not notified by the facility. FA-A discovered R50's hearing aids were missing when R50 could not hear her during an evening visit. FA-A indicated when she brought it to the attention of the nurse manager and the social worker they were not aware the hearing aids had been missing. FA-A indicated R50 had misplaced

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 246	Continued From page 11	F 246		

her hearing aids in 2015 and the replacements were covered by insurance. FA-A was not aware if Medicaid would pay for another replacement so soon and was currently waiting for the insurance decision. FA-A stated R50 seemed to be increasingly confused since her hearing aids went missing.

During observation on 7/25/17, at 5:34 p.m. R50 sat at the dinner table with two other residents and (NA)-C, who sat right next to R50. At 5:48 p.m. NA-C spoke directly into R50's right ear and had to repeat herself several times, after R50 stated "Huh? Huh?" R50 then turned to her tablemate and stated, I just heard my name and that was about it. NA-C explained R50 did not have her hearing aids for about a month because they were broken and did not fit her ears right so they were getting fixed. NA-C stated R50 had been more confused without her hearing aids and thought when she could hear better she wasn't so confused. NA-C indicated one ear was no better than the other and stated she had to talk louder.

During observation on 7/25/17, at 6:30 p.m. R50 sat at a table with a couple other residents to play bingo. The bingo numbers were called by a computer software program which also projected the numbers onto a TV screen at the front of the room (surveyor was sitting adjacent to R50, and the numbers were difficult to see from viewing point). Several numbers were called, after each number R50 looked around the room, attempted to see tablemate's card, appeared frustrated, stated to her tablemate she could not hear, and shook her head. Halfway through the game, activity aide (AA)-B sat down at the table across from R50, and assisted R50 to find the number on her card. At 6:36 p.m., R50 stated to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 246	Continued From page 12	F 246		

surveyor she could not hear the numbers called. At 6:38, a new game of bingo started, the volume was turned up and the speed of the announcer was slowed down. When R50 could hear the numbers she was actively engaged and was able to correctly mark the numbers on her card. The numbers that R50 could not hear, were pointed out by AA-B.

During interview on 7/25/17 at 7:37 AA-B indicated she was not aware R50's hearing aids were missing. AA-B, explained if R50 couldn't hear at bingo then the staff would play the cards for her. AA-B reported staff had not tried any other interventions that would allow R50 to play her bingo cards herself. In response to the question, how is R50 participating in the activity if the staff play the card for her?, AA-B stated, that's a good question.

During interview on 7/25/17, 7:47 p.m. AA-A stated she was not aware of the missing hearing aids, however, noticed R50 did not have them in tonight. AA-A reported it seemed like R50 seemed to be struggling more recently to hear and staff just had to speak more loudly to her.

On 7/26/17, at 10:31 a.m. registered nurse (RN)-D explained R50 had a history of taking her hearing aids out and putting them in places such as puzzle boxes. RN-D went on to state that staff removed hearing aids at bedtime and stored them in the medication cart and then put them back in in the morning. RN-D indicated she was unaware the hearing aids were missing until 6/1/17 and stated that an interim care plan or revision of the care plan was not completed to reflect the missing hearing aids because all staff knew they had to speak more loudly so she could

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 246	Continued From page 13	F 246		

hear them. RN-D indicated R50 was not assessed for ways to accommodate the hearing loss related to the missing hearing aids such as a pocket microphone or white board. RN-D explained R50 had increased confusion, however that started before the hearing aids went missing. RN-D was not aware of when and if R50's hearing aides would be replaced as the facility was waiting for the insurance decision.

During interview on 7/26/17, at 11:14 a.m. (NA)-D explained R50 lost her hearing aids recently and that NA-D communicated with her by speaking into her right ear because that's the ear R50 pointed to when she couldn't hear her.

During interview on 7/26/17, at 11:57 a.m. licensed social worker (LSW)-A stated she was made aware of the missing hearing aids on 5/24/17 by FA-A. LSW-A indicated the care plan should have been revised by nursing including accommodations that would help R50 to adapt to the hearing loss. LSW-A stated interventions such as a white board or pocket microphone were not in place and was not aware of any attempts made to use other forms of communication. LSW-A explained the facility was waiting for the insurance coverage decision, was not aware of how long the claim would be in processing, and did not know what the plan would be for replacement if the insurance was not going to cover the cost.

During interview on 7/28/2017, at 8:14 a.m. activity director (AD) indicated R50 had a problem with hearing with her hearing aids in. AD indicated when residents were hard of hearing staff played the bingo cards for them; and explained even though hard of hearing residents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 246	Continued From page 14 could not directly participate in the bingo, the activity was a social setting for them. AD stated no other means of communication were attempted by activity staff for R50. During interview on 7-28-17, at 10:22 a.m. the director of nursing indicated an interim care plan should have been developed after the hearing aids went missing or the care plan should have been revised to include interventions that would accommodate R50's hearing loss without the aids. A facility policy was requested and not received.	F 246		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the	F 280		9/5/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 280	Continued From page 15	F 280		

right to sign after significant changes to the plan of care.

(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--

(i) Facilitate the inclusion of the resident and/or resident representative.

(ii) Include an assessment of the resident's strengths and needs.

(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.

483.21
(b) Comprehensive Care Plans

(2) A comprehensive care plan must be-

(i) Developed within 7 days after completion of the comprehensive assessment.

(ii) Prepared by an interdisciplinary team, that includes but is not limited to--

(A) The attending physician.

(B) A registered nurse with responsibility for the resident.

(C) A nurse aide with responsibility for the resident.

(D) A member of food and nutrition services staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 280	Continued From page 16 (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to revise and update the care plan related to need for communication accommodations after hearing aids went missing for 1 of 1 resident (R50) reviewed for social services. Findings include: R50's annual Minimum Data Set (MDS) dated 3/8/17, indicated R50 had severe cognitive impairment, used hearing aids, and had moderate difficulty hearing with hearing aids present. R50's quarterly MDS dated 6/6/17, indicated R50 did not have hearing aids and the speaker had to increase volume and speak distinctly. A quarterly review progress note, dated 6/7/17, indicated R50 used hearing aids for both ears however, the hearing aids were missing, and the facility was	F 280	a)Resident 50 had lost hearing aids and was unable to properly hear staff in activities or during cares. Care plan revision was done. Resident had some issues with hearing activities; however there were no lasting effects. b) All residents would be considered to be at risk if the care plan updating was not completed related to changes in condition. c) Communication care plan was updated by RN manager on 8/7/17 to reflect that hearing aids are missing, and facility/family are in the process of replacing them. Special approaches are to be taken while hearing aids are missing, raise the volume of speakers voice, obtaining residents attention prior to speaking, asking simple questions and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 280	Continued From page 17 working to replace them. R50's communication care plan dated 3/8/16 indicated R50 had hearing impairment, utilized hearing aids for both ear which enhanced her hearing, R50 was able to hear adequately with the use of the aids, and usually able to make herself understood and usually understood others. The care plan directed staff to provide a quiet non-hurried environment free of background noises and distraction, assist R50 with placing hearing aids in the morning, and speak into ear with hearing aid present for better hearing. The care plan also directed to repeat/rephrase as necessary, and allow adequate time for R50 to finish and communicate thoughts, however, R50's care plan was not revised to reflect the missing hearing aids, nor interventions that would accommodate the loss of hearing without the aids present. On 7/24/17, at 11:41 a.m. R50 did not have hearing aids in her ears. During conversation with R50, surveyor had to speak loudly and directly into either of R50's ears and frequently had to repeat and or rephrase statements and questions. When R50 could hear surveyor, answers or responses were appropriate for questions or topic. During an interview on 7/25/17, at 1:52 p.m. R50's family member (FA)-A stated both R50's hearing aids went missing more than a month ago and was not notified by the facility. FA-A discovered R50's hearing aids were missing when R50 could not hear her during an evening visit. FA-A indicated when she brought it to the attention of the nurse manager and the social worker and both were not aware the hearing aids	F 280	rephrasing questions as needed. This information was relayed to charge nurse on 8/7/17. Resident information sheet was updated to reflect the missing hearing aids and that resident hears best in her right ear. When any resident loses or misplaces any equipment needed for best possible function, such as glasses, hearing aides, braces, the care plan will be updated. Care plan updating will be reviewed reviewed and/ or assigned at M-F daily clinical meeting by DON. d.) DON will report to QAPI the results of successful care plan updating and adjust plan if needed. e.)Corrective action to be completed on or before 9/5/2017. DON is responsible.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 280	Continued From page 18	F 280		

had been missing. FA-A stated R50 seemed to be increasingly confused since her hearing aids went missing.

At 7:37 (AA)-B indicated she was not aware R50's hearing aids were currently missing. AA-B, explained if R50 couldn't hear at bingo then the staff would play the cards for her. AA-B reported staff had not tried anything else to assist R50 in order to play her bingo cards herself. In response to the question, how is R50 participating in the activity if the staff play the card for her?, AA-B stated, that's a good question.

At 7:47 p.m., AA-A stated she was not aware of the missing hearing aids however, noticed R50 did not have them in tonight. AA-A reported it seemed like R50 seemed to be struggling more recently to hear and staff just had to speak more loudly to her.

On 7/26/17, at 10:31 a.m. registered nurse (RN)-D explained R50 had a history of taking her hearing aids out and putting them in places such as puzzle boxes, staff removed hearing aids at bedtime, stored them in the medication cart, and in the morning put them back in. RN-D indicated an unawareness of the missing hearing aids until 6/1/17 and reported an interim care plan or revision of the care plan was not completed to reflect the missing hearing aids because all staff knew they had to speak more loudly so she could hear them. RN-D indicated R50 was not assessed for ways to accommodate the hearing loss related to the missing hearing aids such as a pocket microphone or white board. RN-D explained R50 had increased confusion, however that started before the hearing aids went missing. RN-D was not aware of when or if R50's hearing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 280	Continued From page 19 aids would be replaced as the facility was waiting for the insurance decision. On 7/26/17, at 11:57 a.m. licensed social worker (LSW)-A stated she was made aware of the missing hearing aids on 5/24/17 by FA-A. LSW-A indicated the care plan should have been revised by nursing. LSW-A indicated accommodations that would help R50 to adapt to the hearing loss such as a white board or pocket microphone were not in place and was not aware of any attempts made to use other forms of communication. LSW-A explained the facility was waiting for the insurance coverage decision, was not aware of how long the claim would be in processing, and did not know what the plan would be for replacement if the insurance was not going to cover the cost of replacement. At 10:22 a.m. the director of nursing indicated an interim care plan should have been developed after the hearing aids went missing or the care plan should have been revised to include interventions that would accommodate R50's hearing loss without the aids. A facility policy was requested and not received.	F 280		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care.	F 282		9/5/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 282	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide timely toileting, and pressure relieving interventions according to the care plan for 1 of 1 residents (R48) reviewed for urinary incontinence and pressure ulcers (PU). Findings included: R48's bowel and bladder care plan dated 5/13/16, indicated R48 was frequently incontinent of bowel and bladder and required 1-2 staff assistance with a mechanical lift for toileting needs. The care plan directed staff to toilet before and after meals. R48's urinary incontinence care plan dated 1/4/17, indicated R48 had functional urinary incontinence related to being unable to reach toilet in time do to diagnosis of Alzheimer's, pain in foot, diabetes type II, and hypertension. The care plan directed staff to check for incontinent episodes at least every two hours, provide incontinence care after each incontinent episode, and report any signs of skin breakdown. R48's pressure ulcer (injury to skin and underlying tissue caused by prolonged pressure) care plan dated 1/4/17, indicated R48 was at risk for pressure ulcers due to impaired sensory perception due to activity and was chair fast. The care plan directed staff to perform skin assessments and inspections every shift with close attention to heels, elevate heels, use heel protectors, use pillows between knees and body prominence's to avoid direct contact, pad bony prominence's with foam wedges, rolled blankets, or towels.	F 282	a) Resident 48 has a toileting schedule of approximately every two hours. Resident has no open areas related to incontinence or offloading in wheelchair. Resident has a pressure ulcer on the left heel noted on 7/10/17, care plan has general toileting schedule of approximately every two hours. b) All residents would be considered at risk for skin break down due to lack of repositioning and/or incontinence. c) Incontinent and residents requiring assist with repositioning, care plans will be reviewed by RN manager on or before 8/31/17 and revised as needed. RN managers and charge nurse will place laminated cards under residents to spot check for repositioning and incontinence care. The cards will have instructions to return to charge nurse when found to determine whether or not care plan is being followed on that particular resident. Results of this process will be recorded on a repositioning/incontinence log. An in-service for all nursing staff will occur on or before September 5th, 2017 in regards to following care plans and interventions. Spot checks will be performed by RN managers and charge nurses to ensure repositioning of residents is being done, and care plans are being followed. d) The results of this process will be reported to QAPI by DON to determine whether it needs to be continued on a	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 282	Continued From page 21 R48's skin care plan dated 5/13/16, indicated R48 had a stage II PU to left heel and a stage I PU to right heel and directed staff to turn and reposition approximately every two hours, assist remind her as needed. The care plan also directed staff to follow treatments as indicated in the treatment administration record (TAR). R48's July's TAR included an order from 7/16/17 through 7/27/17, which directed staff to put the blue boots on and float heels when in bed at all times. The order was revised on 7/27/17, which directed staff to put the blue boots/sheep skin on at all times, and float heels when in bed. On 7/24/17, at 10:10 a.m. R48 sat in her wheelchair with gripper socks on; her left heel was resting on the metal foot pedal with the top portion of her foot off the food pedal. Blue boots were not noted to be visible in R48's room at the time of the observation. On 7/25/17, at 1:22 p.m. R48 laid in bed with her eyes closed. R48 was positioned on her back with a pillow slightly tucked under her right side. R48 had blue gripper socks on, did not have blue boots on, and heels were directly on the bed and were not floated. The blue boots were not visible in her room and no other pillows or pressure relieving devices were noted to be on, near, or around the bed. A continuous observation was started on 7/25/17, at 5:09 p.m. and ended at 8:23 p.m. The observation and follow-up interviews revealed R48 was not repositioned or taken to or offered the restroom for at least 3 hours and 30 minutes based on the following information.	F 282	regular basis or as a spot check. Corrective action will be completed on or before 9/5/17 DON is responsible.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 282	Continued From page 22	F 282		

-At 5:09 p.m., one blue boot was noted in R48's rocking chair in her room.

-At 5:11 p.m., R48 sat in her wheelchair in the dining room eating her evening meal. R48 had blue gripper socks on and left heel rested directly on the metal foot pedal with the top of her foot off, the right foot was not touching the foot pedal.

-At 6:02 p.m., R48 was wheeled out in her wheelchair by registered nurse (RN)-D from the dining room and placed in the hallway adjacent to dining room.

-At 6:14 p.m., RN-D then pushed R48 in her wheelchair back into the dining room area to play bingo. At 7:21 p.m. bingo ended.

-From 7:21 p.m. to 7:56 p.m., R48 sat in the dining room until an unidentified activities staff member wheeled her out and placed her in front of the nursing station adjacent to the dining room.

-At 8:04 p.m. nursing assistant (NA)-F and NA-E wheeled R48 to her room and assisted her to the restroom where she voided a small amount after several minutes of sitting on the toilet. NA-F verified R48's incontinent garment was totally saturated with urine that had a strong foul odor.

-At 8:09 p.m., NA-F stated R48 was always incontinent of urine and he got her up between 4:00 and 4:30 p.m. NA-F explained R48 was supposed to be repositioned and toileted every two hours however, didn't have time to reposition or take R48 to the restroom because R48 went right from dinner to the activity. NA-F reported when he got R48 out of bed she had the blue boots on and they were removed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 282	Continued From page 23	F 282		

-At 8:20 p.m., R48 was assisted to lay down in bed. The left heel had a foam dressing held in place by tegaderm; the skin visible outside the top of foam dressing that was only covered by the tegaderm was reddened and slow to blanch. NA-E stated R48 was supposed to have blue boots for both feet however, didn't think she had ever had two blue boots and staff used the lamb's wool heel protector instead. NA-E applied the lamb's wool heel protector to the left foot, blue boot to the right foot, and floated both heels on a pillow.

On 7/26/17, at 9:40 a.m. RN-D indicated the heel PU's were discovered on 7/10/17. RN-D reported the interventions that were put into place to prevent further skin breakdown included pressure relieving blue boots on and heels floated when in bed at all times. RN-D explained, R48's foot rests did not have the backs, so the pressure relieving boots did not have to be on while up in the chair. RN-D indicated if R48's heels rested on the foot rests, then R48 should have the boots on at all times. RN-D stated R48 was at risk for pressure ulcers, required repositioning every two hours, and the pressure relieving boots should have been applied and heels floated while in bed. RN-D also explained R48 did not always tell staff when she needed to use the restroom, was frequently incontinent of bowel and bladder, and staff were to take R48 to the restroom every two hours (give or take 30 minutes).

On 7/28/17, at 10:10 a.m. director of nursing (DON) stated she expected staff follow the care plan for urinary incontinence and pressure ulcers.

A facility policy was requested and not received.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide timely toileting assistance for 1 of 1 residents (R48) reviewed for bowel and bladder incontinence that were dependent on staff for care. Findings include: R48's Diagnoses Report dated 7/28/17, included diabetes type II, chronic kidney disease stage 3, urinary incontinence, and weakness. R48's quarterly Minimum Data Set (MDS) dated 6/23/17, indicated R48 had severe cognitive impairment, was dependent on one staff for toileting, and required extensive assistance from one staff for transfers and personal hygiene. The MDS also indicated R48 was not on a toileting program and was frequently incontinent of urine and occasionally incontinent of bowel. R48's quarterly assessment progress note dated 6/27/17, included R48 was frequently incontinent of bladder and occasionally incontinent of bowel. The note indicated R48 sometimes verbalized toileting needs, at other times staff needed to anticipate needs, and required total assistance to use the bathroom. R48's bowel and bladder care plan dated 5/13/16, indicated R48 was frequently incontinent of bowel	F 312	a) Resident 48 has a toileting schedule of approximately every two hours. NO harm or injury was noted along with any signs or symptoms of pain to this resident by missed repo. Resident had no open areas related to incontinence or offloading in wheelchair. b) All residents would be considered at risk for skin breakdown due to lack of repositioning and/or incontinence if care plan is not in place to address. c) Incontinent and immobile residents care plans will be reviewed by RN manager on or before 8/31/17 and revised as needed. RN managers and charge nurse will place laminated cards under residents to spot check for repositioning and incontinence care. The cards will have instructions to return to charge nurse when found to determine whether or not care plan is being followed on that particular resident. Results of this process will be recorded on a repositioning/incontinence log. This will be ongoing. An in-service for all nursing staff will occur on or before September 5th, 2017 in regards to following care plans and interventions. Spot checks will be performed by RN managers and charge	9/5/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 312	Continued From page 25 and bladder and required 1-2 staff assistance with a mechanical lift for toileting needs. The care plan directed staff to toilet before and after meals. R48's urinary incontinence care plan dated 1/4/17, indicated R48 had functional urinary incontinence related to being unable to reach toilet in time do to diagnosis of Alzheimer's, pain in foot, diabetes type II, and hypertension. The care plan directed staff to check for incontinent episodes at least every two hours, provide incontinence care after each incontinent episode, and report any signs of skin breakdown. A continuous observation was started on 7/25/17, at 5:09 p.m. and ended at 8:23 p.m. The observation and follow-up interviews revealed R48 was not taken to or offered the restroom for at least 3 hours and 30 minutes. -At 5:11 p.m., R48 sat in her wheelchair in the dining room eating her evening meal. -At 6:02 p.m., R48 was wheeled out in her wheelchair by registered nurse (RN)-D from the dining room and placed in the hallway adjacent to dining room. -At 6:14 p.m., RN-D then pushed R48 in her wheelchair back into the dining room area to play bingo. At 7:21 p.m. bingo ended. -From 7:21 p.m. to 7:56 p.m., R48 sat in the dining room until an unidentified activities staff member wheeled her out and placed her in front of the nursing station adjacent to the dining room. -At 8:04 p.m. nursing assistant (NA)-F and NA-E wheeled R48 to her room and assisted her to the	F 312	nurse to ensure repositioning of residents is being done, and care plans are being followed. d) The results of this process will be reported to QAPI to determine whether it needs to be continued on a regular basis or as a spot check only. Corrective action will be completed on or before 9/5/2017/ DON is responsible.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 312	Continued From page 26 restroom where she voided a small amount after several minutes of sitting on the toilet. NA-F verified R48's incontinent garment was totally saturated with urine that had a strong foul odor. -At 8:09 p.m. NA-F stated R48 was always incontinent of urine and reported he had gotten her up between 4:00 and 4:30 p.m. NA-F explained R48 was supposed to be toileted every two hours however, didn't have time because R48 went right from dinner to the activity. On 7/26/17, at 9:40 a.m. RN-D also explained R48 did not always alert staff when she needed to use the restroom, was frequently incontinent of bowel and bladder, and staff were to take R48 to the restroom every two hours (give or take 30 minutes). On 7/28/17, at 10:10 a.m. director of nursing (DON) stated she expected staff follow the care plan for urinary incontinence.	F 312		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives	F 314		9/5/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 314	Continued From page 27 necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide timely repositioning in order to prevent and/or minimize the risk of pressure ulcer development and failed to ensure care plan interventions were consistently followed to promote healing or prevent worsening of a left heel stage 2 pressure ulcer (PU) and right heel stage 1 PU for 1 of 1 residents (R48) reviewed for pressure ulcers. Findings include: R48's Diagnoses Report dated 7/28/17, included diagnoses of: diabetes type II, weakness, dermatitis, unspecified eczema (itchy, red, swollen, and cracked skin, affected people have an increased risk of skin infections) chronic kidney disease stage 3, peripheral vascular disease, localized edema, dementia, Alzheimer's disease, and urinary incontinence. R48's quarterly Minimum Data Set dated 6/23/17, indicated R48 had severe cognitive impairment and required extensive assistance from two staff members for bed mobility, was dependent on one staff for toileting, and extensive assist of one staff member for hygiene and dressing. The MDS further indicated R48 was frequently incontinent of urine, occasionally incontinent of bowel, was at risk for pressure ulcers (injury to skin and underlying tissue caused by prolonged pressure), did not have any pressure ulcers, and required	F 314	a) Resident 48 has had no worsening of existing pressure ulcer, as well as no new pressure areas. b) All residents would be considered at risk for complications due to care plans not being updated as condition changes occur. c) Care plan was updated on 7/27/17 to reflect Allyven hell protectors to bilateral heels and protective boot to left heel, sheep skin to right heel on at all times and to float heels when in bed. Care plans will be reviewed by RN managers by 8/31/17 and revised as needed and then quarterly and with any condition changes. Wound rounds is completed on all active wounds at least weekly, wound assessments are reviewed by RN manager, to ensure completion is done. Charge nurses will be in-serviced on new procedure for checking re-positioning, laminated cards will be placed under residents,with a note to return to nurse when found, a log will be kept. d.)DON will report to QAPI on outcomes and determine whether any changes needed to process. e) Corrective action to be completed on or before 9/5/2017.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 314	Continued From page 28 pressure reducing devices for wheelchair and bed. R48's bowel and bladder care plan dated 5/13/16, indicated R48 was frequently incontinent of bowel and bladder and required 1-2 staff assistance with a mechanical lift for toileting needs. The care plan directed staff to toilet before and after meals. R48's urinary incontinence care plan dated 1/4/17, indicated R48 had functional urinary incontinence and directed staff to check for incontinent episodes at least every two hours, provide incontinence care after each incontinent episode, and report any signs of skin breakdown. R48's pressure ulcer care plan dated 1/4/17, indicated R48 was at risk for pressure ulcers due to impaired sensory perception due to activity and was chair fast. The care plan directed staff to perform skin assessments and inspections every shift with close attention to heels, elevate heels, use heel protectors, use pillows between knees and body prominence's to avoid direct contact, pad bony prominence's with foam wedges, rolled blankets, or towels. R48's skin care plan dated 5/13/16, indicated R48 had a history of severe itching thought to be from dryness, had a stage II PU (partial thickness of skin loss that is superficial and presents as an abrasion, blister, or shallow crater) to left heel and a stage I PU (intact skin that presents as an area of redness that does not change or lose color briefly when you press your finger on it and then remove your finger) to right heel and directed staff to turn and reposition approximately every two hours, assist remind her as needed. The care plan also directed staff to follow treatments as indicated in the Treatment	F 314	DON is responsible.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 314	Continued From page 29	F 314		

Administration Record (TAR).

R48's July's TAR included an order from 7/16/17 through 7/27/17, which directed staff to put the blue boots on and float heels when in bed at all times. The order was revised on 7/27/17, which directed staff to put the blue boots/sheep skin on at all times, and float heels when in bed.

R48's Braden skin assessment (tool used to predict PU risk) dated 6/23/17, indicated R48 was at high risk for developing pressure ulcers related to very limited sensory perception, had very moist skin, was chair fast, had very limited mobility, probably had inadequate nutrition, and had a potential problem with friction and shear.

R48's Tissue Tolerance Testing (tool to determine skin's tolerance to pressure over bony prominence's) dated 12/20/16, indicated R48 required every two hour repositioning in the wheelchair and in bed.

R48's Skin Integrity Event assessment dated 7/10/17, indicated both heels were peeling and red, left heel had a blister. The left heel PU measured 0.9 centimeters (cm) by 0.4 cm, and identified as a stage 1. The right heel was not staged or measured on 7/10/17. The assessment indicated blue boots were provided to be worn at all times while in bed and to float heels while in bed; the physician was notified. A skin progress note dated 7/11/17, indicated the physician stated, off-loading is of greatest importance. Skin Integrity event dated 7/13/17, identified the right heel PU as a stage 1 PU that measured 5.0 cm by 3.0 cm and indicated the same interventions as identified on 7/10/17. Skin Integrity Events notes dated 7/20/17, indicated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 314	Continued From page 30	F 314		

both pressure ulcers had not increased in stage and had slightly decreased in size (complete assessments were requested and not received.)

During observation on 7/24/17, at 10:10 a.m. R48 sat in her wheelchair with gripper socks on; her left heel was resting on the metal foot pedal with the top portion of her foot off the foot pedal. Blue boots were not noted to be visible in R48's room at the time of the observation.

On 7/25/17, at 1:22 p.m. R48 laid in bed with her eyes closed. R48 was positioned on her back with a pillow slightly tucked under her right side. R48 had blue gripper socks on, did not have blue boots on, and heels were directly on the bed and were not floated. The blue boots were not visible in her room and no other pillows or pressure relieving devices were noted to be on, near, or around the bed.

A continuous observation was started on 7/25/17, at 5:09 p.m. and ended at 8:23 p.m. The observation and follow-up interviews revealed R48 was not repositioned or taken to or offered the restroom for at least 3 hours and 30 minutes based on the following.
-At 5:09 p.m., one blue boot was noted in R48's rocking chair in her room.
-At 5:11 p.m., R48 sat in her wheelchair in the dining room eating her evening meal. R48 had blue gripper socks on and left heel rested directly on the metal foot pedal with the top of her foot off, the right foot was not touching the foot pedal.
-At 6:02 p.m., R48 was then wheeled in her chair by registered nurse (RN)-D from the dining room and placed in the hallway adjacent to dining room. R48 was not repositioned or offered toileting. R48's left heel rested directly on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 314	Continued From page 31	F 314		

wheel chair foot rest and right foot was in-between the foot rests.
-At 6:14 p.m., RN-D then pushed R48 in her wheelchair back into the dining room area to play bingo. At 7:21 p.m. bingo ended.
-From 7:21 p.m. to 7:56 p.m., R48 sat in the dining room until an unidentified activities staff member wheeled her out and placed her in front of the nursing station adjacent to the dining room.
-At 8:04 p.m., nursing assistant (NA)-F and NA-E took R48 to her room and assisted her to the restroom where she voided a small amount after several minutes of sitting on the toilet. NA-F verified R48's incontinent garment was totally saturated with urine had a strong foul odor. R48's bottom did not show areas of redness caused by pressure or incontinence, however, her bottom was speckled with small slightly pink dermatitis lesions. NA-F and NA-E explained R48 had a history of dermatitis, had tendency to scratch her bottom, and creams were used to help with the itching.
-At 8:09 p.m., NA-F stated R48 was always incontinent of urine and he had gotten her up between 4:00 and 4:30 p.m. NA-F explained R48 was supposed to be repositioned and toileted every two hours, however, didn't have time to reposition or take R48 to the restroom because R48 went right from dinner to the activity. NA-F reported when he got R48 out of bed she had the blue boots on and they were removed.
-At 8:20 p.m., R48 was assisted to lay down in bed. The left heel had a foam dressing held in place by tegaderm, the skin visible outside the top of foam dressing that was only covered by the tegaderm was reddened and slow to blanch. NA-E stated R48 was supposed to have blue boots for both feet, however, didn't think she had ever had two blue boots and staff used the lamb's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 314	Continued From page 32	F 314		

wool heel protector instead. NA-E applied the lamb's wool heel protector to the left foot, blue boot to the right foot, and floated both heels on a pillow.

On 7/27/17, at 1:40 p.m. RN-D and licensed practical nurse (LPN)-A removed heel dressings, right heel appeared pink, dry with peeling skin, boggy, and was slow to blanch. The left heel PU measured 0.2 cm by 0.4 cm, wound bed could not be visualized related to slough or scab, and was pink around the wound periphery. RN-D reported the right heel continues to be a stage I and the left heel continues as a stage II.

On 7/26/17, at 9:40 a.m. RN-D indicated the heel PUs were discovered on 7/10/17, and stated the assessment should have reflected the left heel had a stage II PU and not a stage I and indicated the right heel was not measured on 7/10/17, and probably should have been. RN-D reported the interventions that were put into place to prevent further skin breakdown included pressure relieving blue boots on and heels floated when in bed at all times. RN-D explained, R48's foot rests did not have the backs, so the pressure relieving boots did not have to be on while up in the chair. RN-D indicated if R48's heels rested on the foot rests, then R48 should have the boots on at all times. RN-D stated R48 was at risk for pressure ulcers, required repositioning every two hours, and the pressure relieving boots should have been applied and heels floated while in bed. RN-D also explained R48 did not always tell staff when she needed to use the restroom, was frequently incontinent of bowel and bladder, and staff were to take R48 to the restroom every two hours (give or take 30 minutes).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 314	Continued From page 33 On 7/28/17, at 10:10 a.m. director of nursing (DON) stated she expected staff follow the care plan for urinary incontinence and pressure ulcers. A pressure ulcer policy was requested and not received.	F 314		
F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to followed	F 323	Resident 84 had a fall from the EZ/full lift during a transfer. The stitching on the	9/5/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 323	Continued From page 34 manufacturer's instruction to ensure full body lift slings and stand lift harnesses were free of wear and tear and safe to use for transfers for 1 of 3 (R84) residents reviewed for accidents. This resulted in actual harm to R84, when a sling ripped during a transfer causing R84 to fall to the floor resulting in a laceration to the back of the head. In addition, the facility failed to assess the safety and risk of entrapment of side rails/grab bars for 1 of 3 residents (R6) reviewed for accidents. Findings include: R84's admission Minimum Data Set (MDS) assessment, dated 2/13/17, indicated R84 was totally dependent and required 2+ person physical assist for transfers. The Care Area Assessment (CAA), dated 2/14/17, indicated R84 had diagnoses, which included multiple sclerosis with quadriplegia. R84 was completely dependent for activities of daily living and mobility. R84 transferred with the assistance of two staff and an EZ (full body) lift for all transfers. R84's quarterly MDS dated 5//16/17, indicated moderate cognitive impairment. R84's care plan, last review date of 7/25/17, indicated R84 required assistance of 2 staff and an EZ lift for all transfers. The care plan indicated R84 had a witnessed fall on 7/6/17. On 7/7/17 an intervention to make sure the EZ lift sling was double looped at all times was added to R84's care plan. An Event Report, dated 7/6/17, indicated R84 fell from an EZ lift during a transfer from the bed to a wheelchair around 3:45 p.m. on 7/6/17. Two nursing assistants (unidentified) assisted with the	F 323	black loop, which is the shortest loop on the sling, came undone. This resulted in resident falling to the floor. Resident sustained an injury. These injuries are healed and resident does not have any lasting effects from the incident. b) All residents would be considered at risk if sling and/or harness stitching tears or frays. This sling appears to be in very good condition, and facility believes following investigation that this was equipment failure. c) The policy and procedure has been updated. All nursing staff will do a return demonstration of the EZ stand and EZlift use and show competency with the Staff Development Coordinator. They will demonstrate the checking of the sling or harness prior to each use. RN managers will complete an audit and create a log with the results of the audit of slings and harness by checking them monthly x three months and then quarterly. Slings and harness will be replaced annually on or before this time if there are tears, rips, frays, etc. All slings an harnesses that are over a year old from the date they were put into service will be replaced on or before 8/28/17. service. Return demonstration and EZ lift use by all nursing staff will be completed on or before 8/25/17. Annual in-service will be held on proper EZ stand and EZ lift use. These in-services will be on-going. d) The results of this process will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 323	Continued From page 35 transfer. While one nursing assistant assisted R84's feet/legs off the bed, a second nursing assistant maneuvered the lift. As soon as R84's feet were off of the bed, the sling loop ripped. The report lacked documentation identifying which of the sling's 4 loops ripped. R84 fell to the floor, hitting his head/upper body first. Several nurses responded. R84 was bleeding from the back of the head. R84 complained of pain to the back of the head, rating the pain 5 out of 10 (10 being the most severe pain). Staff called for emergent transportation around 4:00 p.m. Emergency services arrived around 4:10 p.m., and R84 was transported to the hospital at 4:14 p.m.. The facility's fall investigation, dated 7/12/17, identified two nursing assistants that will be identified as nursing assistant (NA)-G and nursing assistant (NA)-H. The investigation indicated the facility purchased the sling in November 2016 and following the fall, a representative (rep)-D from the EZ Way lift company came to the facility and inspected all the lift slings and stand harnesses with the director of nursing (DON). In addition, the investigation indicated "It has been policy that both laundry and nursing staff inspect slings for any fraying or other problems. This policy has been followed." Policy changed so all lift transfers will be double looped. Hospital documentation, dated 7/6/17, indicated that R84 had head trauma after falling 4 feet from a lift. R84 reported pain to the back of the head. R84 had two curved lacerations measuring approximately 2.0 inches each in length on the left occipital (back of head) region and a subcutaneous hematoma (bruise) to the left parietal occipital (mid to lower back of head) region. The left lateral laceration was repaired	F 323	reported to QAPI by DON to determine whether further education/training needs to be continued on a regular basis. Corrective action will be completed on or before 8/28/2017. DON is responsible. SODE RAO:S a) Resident R6 has personal grab bar which was removed from the bed and family took it home. The window side of bed half rail was removed as she does not use it and it was replaced with a facility approved grab bar. Her door side half side rail remains in place. An updated adaptive equipment use assessment was completed on 8/15/17 and a new consent form was signed the same day after reviewing safety and entrapment risks of side rail/grab bar with resident. No evidence of harm, b) All residents could be considered at risk if adaptive equipment use assessments and review of safety and entrapment risk of side rails/grab bars in not completed. c) RN managers will complete an adaptive equipment use assessment on any new residents and quarterly or with change of condition including cognition and also review safety and entrapment risks	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 323	Continued From page 36	F 323		

with Dermabond (skin glue.) The right laceration was closed with 11 sutures.

R84's progress notes, dated 7/6/17, indicated R84 returned the same day at 9:45 p.m..

During interview on 7/25/17, at 6:15 p.m. NA-G stated NA-H assisted with the transfer. NA-G stated he looked at the sling prior to use and did not see any rips or frays. NA-G stated both staff attached the four loop straps to the lift. NA-G stated he placed all three loops of the strap (triple looped) on the hook on the lift, stating only the shortest one is tight. NA-G was unsure which straps he attached to the lift and which straps NA-H attached. NA-H lifted R84 into the air. NA-G stated he believed all loop straps were attached to the lift. NA-G guided R84's feet off the bed, while NA-H moved the lift. NA-G stated the lift was about 4-5 feet from the bed, when one of the loops broke. NA-G stated he believed it was the top right loop strap. NA-G went on to say the loop thread ripped and R84 fell to the floor.

During an interview on 7/26/17 at 11:34 am, the DON stated she responded to R84's room after the fall, and added, "The aides told me the loop fell off." The DON brought out the sling used during the fall. The black loop (shortest of the 3 loops on the strap) on the upper left shoulder side was ripped at the stitching. The loop was open and no longer intact. There was no other wear, tear, or fraying on the sling. The sling was dated November 2015 (different from the fall investigation report that indicated a purchase date of November 2016). The DON stated slings are dated when they arrive at the facility, and it is unknown when the sling was put into use. The DON stated, "We always check for fraying." The

quarterly with family/resident. Side rails and/or grab bars will be removed if no longer appropriate for use for the resident being reviewed.

d) Side rail appropriateness and/or elimination will be reviewed at QAPI.

Corrective action will be ongoing.

DON is responsible.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 323	Continued From page 37	F 323		

DON stated rep-D came out and they looked at all the slings and no slings were frayed. The DON further stated that two slings were older than 2 years and thrown out per rep-D's recommendation. The DON stated rep-D recommended to continue to examine the slings and make sure the slings are laundered properly.

During an interview on 7/26/17, at 12:39 a.m., rep-D stated she came out to the facility after the fall. Rep-D looked at the sling with the ripped loop and sent a picture of the rip to EZ Way corporate staff, who thought the rip was unusual. Rep-D stated the wear of the sling at the site of the rip prior to the fall was not known. Rep-D stated she looked at other full body lift slings and stand lift harnesses while at the facility; however, could not "guarantee" she saw all the slings and harnesses at the facility. Rep-D stated she recommended a couple of stand lift harnesses be removed from use due to age. Rep-D recommended staff look at slings for wear and tear prior to each use. Rep-D stated EZ Way recommends slings are replaced after one year. Rep-D went on to say if the sling used during the fall was over a year old she would have recommended it to be replaced.

During an interview on 7/26/17, at 2:47 p.m. and 7/27/17, at 8:44 a.m. registered nurse (RN)-G stated NA-H was pool staff at the time of the fall. RN-G stated she trains pool staff; however, does not provide training on the lifts to pool staff.

Attached to the lifts was a policy, undated, titled EZ Lift Safety & Maintenance Checklist. #12 of the checklist directed: "Check the entire sling for damage or wear, including the loops and stitching. If damage or wear is present, discard

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 323	Continued From page 38	F 323		

the sling and order a new one. It is recommended that slings be replaced after one year or if the sling shows any sign of damage." Hand written in was: "checked by director of nursing." The policy indicated: "It is the responsibility of the purchaser to ensure that regular maintenance inspection is conducted on the device by competent staff." Attached to the policy was a fill in check list form. #1 to #11 on the check list were filled in with monthly dates and initials. #1 through #11 referred to maintenance of the lift itself, which included checking bolts, cables, wheels, brakes, and for checking damaged, missing, or loose parts. #12 referred to checking the slings. #12 indicated: "Checked by Director of Nursing-Slings." #12 was blank on all the check lists. These checklists contained several months of information with some dating back to 2016.

During a follow-up interview on 7/27/17, at 12:43 p.m. the DON stated pool staff are given orientation on the unit by shadowing another aide. NA-H's competency with the lifts was based on his prior work history of 11 years working as a nursing assistant and having worked at the facility for 9 months without incident. The DON stated the rip in the sling was a result of a defective sling. She went on to state that prior to the fall it was policy for staff to check the slings for wear and tear prior to each use. The DON stated in relation to the manufactures recommendation to replace slings after one year "it's a recommendation, it's not an absolute policy." The administrator joined the interview at the DON's request. The administrator reviewed the manufacturer's recommendations. The administrator stated if the facility's policy was to follow the manufacturer's instructions, the slings need to be replaced yearly. The DON stated due

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 323	Continued From page 39	F 323		

to the large number of older slings, she would inspect all slings by tomorrow and toss any worn slings or slings dated 2013 or older immediately. She stated she would order a few slings at a time and all slings will be under a year old in 90 days. The DON stated after the fall, notices were put up reminding staff to check the slings for wear and tear and not to use if wear or tear was present. In addition, the DON stated she had spoken with the laundry supervisor who told her she always checks for wear and tear of the slings. The DON went on to say she was unaware of the EZ lift checklist relating to the director of nursing checking the slings.

A form provided by the facility identified 24 residents at the facility use a stand lift for transfers and 6 residents use a full body lift for transfers.

Observations of the facility's full body lift slings and stand lift harnesses with the director of nursing on 7/27/17, between 3:07 p.m. and 3:54 p.m. revealed the following:
-1st floor had 7 stand lift harnesses. 3 were not dated and had no wear or tear. 1 had a date of over a year old, with no wear and tear. 1, the DON stated the tag was old and worn and removed from use. The remaining 2 were less than a year old with no wear and tear.
-1st floor: 7 full body slings. None of the 7 slings were dated. The DON stated 3 of the slings had fraying. DON stated 1 of the slings looked old and did not like the way one of the straps looked. The DON removed the 4 slings from use.
-2nd floor: 4 stand lift harnesses. All 4 had dates of over a year old. 1 harness had no wear and tear. The DON identified 3 of the harnesses had fraying and removed the 3 harnesses from use.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 323	Continued From page 40 -2nd floor: 5 full body slings. 3 of the slings were not dated and showed no wear or tear. 1 had a date of over a year with no wear or tear. The DON identified 1 with fraying and removed the sling from use. -3rd floor: 7 stand lift harnesses. 2 had dates of over a year (4/13 and 3/14) with no wear or tear. The DON removed the 2 harnesses from use due to age. The DON removed 2 undated harnesses from use stating the harnesses looked old. The DON removed 1 undated harness from use stating the harness had fraying. 2 harnesses had dates of under a year with no wear and tear. 3 harnesses and 3 full body slings were located in the DON's office. These had been previously removed from first floor by the surveyor on 7/26/17, to investigate condition and age. 1 harness, dated 4/14, had no wear or tear. 1 harness, dated 4/14, had fraying. 1 harness, dated 4/13, had no wear or tear. 1 full body sling had a date over a year old, which the DON stated had no wear. 2 full body sling were undated, which the DON stated had wear. The DON removed the 3 harnesses and 3 full body slings from use. The DON stated after the fall, all the harnesses may not have been checked. During an interview on 7/27/17, at 8:53 a.m. when asked about checking for wear and tear. laundry aide (LA)-B stated she does not check the harnesses. During an interview on 7/24/17, at 1:46 p.m. both NA-I and NA-J stated they were aware of the fall and had received education after the fall to check the slings prior to use for fraying and rips, however, both NA-I and NA-J stated prior to the fall they did not check the slings.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 323	Continued From page 41	F 323		

During interviews on 7/27/17, with 10 nursing assistants, all stated they now inspect the slings for wear and tear prior to use and would not use the sling if wear or tear was present.

The facility's EZ Lift Training Guidelines procedure, dated 5/17/13, indicated a minimum of two staff are needed to operate the EZ lift. The guidelines lacked direction to check the sling for wear and tear.

The facility's policy titled Mechanical Lift Transfers, dated 2008, indicated to Follow Manufacturer's Instructions.

EZ Way manufacturer's manual for the full body and EZ Way stand lift included the following: The pre-operation check directed "Before operating the unit, complete a maintenance safety check for loose nuts and bolts and damaged parts." ... "Also, ensure the sling is not ripped, frayed, or showing signs of wear. EZ Way recommends all slings be replaced after one year, or at the first sign of wear." Additionally the manual indicated: "water washing temperature, detergents and disinfectants, patient incontinence, frequency of use, types and weights of patients, etc., all have an impact on the life expectancy of each product. Because of these factors, the continued integrity of the product is not guaranteed. The user must therefore examine the product to ensure its integrity before each use." ... "Users must accept full responsibility for checking the condition of all slings and harnesses before each and every use on a patient."

SIDE RAILS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 323	Continued From page 42	F 323		

R6's quarterly Minimum Data Set (MDS), dated 5/23/17, identified no cognitive deficit and indicated needing extensive assistance with bed mobility and transfers.

R6's current physician orders indicated she had bilateral half side rails and an additional grab bar to aid in bed mobility and repositioning.

A facility progress note dated 3/6/17, at 2:40 p.m. identified an annual review of R6's adaptive equipment, including bed rails, had been conducted. The note indicated R6 had bilateral quarter rails which were appropriate for her, as she was alert, oriented and could participate in bed mobility. The review lacked documentation of the extra grab bar.

A facility progress note dated 6/5/17, at 6:47 p.m. identified a quarterly review of R6's adaptive equipment had been conducted. This review noted a grab bar on the left side of the bed, along with bilateral half rails that were used to promote R6's mobility. The review indicated the grab bar and side rails were appropriate for R6, since they did not restrain her and "she has adequate upper body strength to push away from the rails."

A Side Rail Consent Form, dated 5/30/17, was signed by R6's power of attorney (POA). The consent included the risks of side rail use attributing to strangulation, injury, and/or death. The consent further indicated "the policy of this facility to use side rail(s) only after an assessment and care planning deem it appropriate," and further identified "In all instances, the least restrictive device, which is effective, will be used." The consent identified a side rail assessment had been completed and maintenance had been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 323	Continued From page 43	F 323		

notified.

R6's care plan, dated 3/21/12, identified the need for assistance with bed mobility. The care plan further directed R6 needed limited to extensive assist of one to two staff, with more assistance needed when weak or tired. It noted R6 was able to participate in some turning/repositioning, using the bed rails, and "She does have an extension to side rail that family wanted."

R6's medical record lacked documentation of any assessment of entrapment risk or alternative to bed rails trialed.

During observation on 7/26/17, at 9:41 a.m. R6 was sitting in her wheelchair. Nursing assistants (NA)-A and NA-B came into the room and transferred R6 from the wheelchair to the bathroom using a standing lift. During observation, bilateral side rails were noted on R6's bed, and on the left side about half way down the bed, a U shaped grab bar was noted. The grab bar was wide, taller than the side rails, and covered with black foam. The grab bar was also observed tucked under the mattress. When checked for for security of the rail connection to the bed, the grab bar was easily slid out from under the mattress, as the bar was not affixed or secured to the bed.

During interview on 7/26/17, at 9:49 a.m. NA-A stated R6's family brought in the grab bar. NA-A stated R6 got out on the right side of the bed, so the grab bar was just for bed mobility with turning at night. NA-A stated R6 needed both the side rail and grab bar on the left side depending on how far down she was in the bed, further stating R6 would slide down in bed and they would boost her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 323	Continued From page 44	F 323		

up, then she could use the side rail instead of the grab bar. NA-A reported R6 needed assistance with turning in bed and could not turn independently.

During interview on 726/17, at 11:21 a.m. R6 stated she had used the grab bar at home and it was easier to hold herself. R6 denied any injury from using the grab bar; however, she denied being told the risks of using it, stating she was just told "as long as it helps."

During interview on 7/28/17, at 8:33 a.m. the director of maintenance (DM) observed the grab bar, stated it was "way to wide," and measured the length and width of the grab bar. DM stated at the widest/tallest points for both width and length were 13 inches. DM stated he received an assessment from nursing to "get the okay" to put grab bars on the beds; however, further reported he had not seen the grab bar and had not put it on the bed. DM stated family probably brought it, stating "yeah need to fix this," acknowledging the grab bar was unsafe because it was not affixed to the bed. The DM stated the facility never installed bars that weren't secured to the bed because of the risk of falling out. He further stated the facility did not measure rails or bars for entrapment, but used manufacture approved side rails with approved sizes. The DM reported "[staff] know better."

During interview on 7/28/17, at 11:09 a.m. registered nurse (RN)-F stated the grab bar was requested by R6's family, so when R6 slid down in bed, it was easier to reach the grab bar. RN-F stated R6 had an assessment, order and a consent for the grab bar, a process which had just been started a couple weeks ago. RN-F

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 323	Continued From page 45 stated prior to that, there was no process for assessing grab bars. RN-F stated the assessment identified if the bar was a restraint and the safety of the resident to use the bar related to medication, falls, and behaviors. RN-F reported the assessment did not address entrapment; however, the consent did identify the risk of it. RN-F did not think the grab bar needed to be affixed to the bed stating R6's weight held it in place, and R6 pull the grab bar towards her, not pushing it away from the bed. During interview on 7/28/17, at 11:53 a.m. the director of nursing (DON) expected residents to be safe while using grab bars, wanting them to be alert and oriented. The DON stated she used to have a 4.5 inch block she would measure for entrapment, but still wanted residents to be safe even if the bars fell into the measurement recommendations. The DON stated the many different kinds of side rails at the facility "makes me nuts," had recently assessed every side rail and grab bar in the facility, and had not found any that big. The DON reported she was not familiar with R6's grab bar; however, the safety of it not being affixed to the bed depended on why R6 used the grab bar. If R6 used it just to turn in bed then it was not an issue, further stating she did not see anything wrong with what they had now. A facility policy was requested but not provided.	F 323		
F 431 SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit	F 431		9/5/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 431	Continued From page 46	F 431		

unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--

(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

(g) Labeling of Drugs and Biologicals.
Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

(h) Storage of Drugs and Biologicals.
(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

(2) The facility must provide separately locked,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 431	Continued From page 47 permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure expired medications were labeled and not administered for 2 residents (R68, R95) who received outdated insulin. In addition, the facility failed to implement controlled substance destruction and storage practices in order to reduce the risk of diversion. This had the potential to affect all residents receiving controlled substances. Findings include: EXPIRED INSULIN R68's quarterly Minimum Data Set, dated 6/21/17, indicated a diagnosis of diabetes mellitus and had received insulin injections during the assessment period. R68's current physician orders identified an order for Lantus (long acting insulin) 26 units at bedtime. R68's Medication Administration Record (MAR), from 7/1/17 to 7/26/17, indicated R68 had received the Lantus insulin every evening during the month. During observation of the Main Street medication cart on 7/24/17, at 12:17 p.m. two of R68's Lantus insulin pens were observed opened but	F 431	Policy states that facility has one key to MedSafe system and pharmacy is to keep the other. The B key has been turned over to pharmacy as of 8/4/17. All other policies regarding MedSafe have been remaining in place. Corrective action completed 8/4/2017. DON is responsible. a) Residents R68 and R95 have no ill effects from insulin administration. b) All residents could be at risk for receiving expired medications if not dated in the med cart. Carts were checked for dated medications, including insulin on 7/28/2017 c) The RN managers, starting 8/21/17 will check med carts weekly for one month for undated medications, and also any medication that are taped if broken or damaged in any way including insulin pens and will check twice per month for one month and then monthly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 431	Continued From page 48 undated in the medication cart. Both Lantus insulin pens were observed with a pharmacy dispense date of 5/30/17, however, the pens were not labeled with an expiration date. R95's Resident Face Sheet indicated a diagnosis of diabetes mellitus with long term insulin use. R95's current physician orders identified an order for Novolog (short acting insulin) 8 units and sliding scale (dose based on blood sugar reading) three times a day. R95's MAR, from 7/1/17 to 7/26/17, indicated he had received the Novolog insulin three times a day since admission to the facility. During observation of the Main Street medication cart on 7/24/17, at 12:17 p.m. R95's Novolog insulin pen was observed opened but undated in the medication cart. The Novolog pen was observed with a pharmacy dispense date of 6/13/17, however, the pen was not labeled with an expiration date. During interview on 7/24/17, at 12:17 p.m. registered nurse (RN)-B verified both R68 and R95 had received the undated insulin. RN-B stated R68 had been at the facility for some time and was not aware why he had two opened Lantus pens, stating the previous nurse must not have seen the opened one. RN-B stated R95 had transferred from a different facility and had brought the insulin pen with upon transfer. RN-B was not aware of the procedure for dating insulin when residents came in with them. RN-B was unsure of the expiration date of insulin once opened, but acknowledged without the open date, she would not know if the insulin expired.	F 431	d) A review of the audits of the med carts will be reviewed at QAPI to determine whether to continue RN Manager audits based on results of RN manager audits. If determined that RN manager audits no longer needed, then a new system will be put in place for cart inspection by charge nurses on a regular basis. Corrective action completed 8/4/17. DON is responsible. STORANGE OF CONTROLLED SUBSTANCES As of 7/28/17 no broken medications will be taped back into the pack. An email has been sent to all nurses to destroy any broken medications and will adjust the narcotic record if the medication in question is a narcotic. Corrected 7/28/17 DON is responsible.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 431	Continued From page 49	F 431		

During interview on 7/26/17, at 2:36 p.m. RN-C stated pharmacy supplied the facility with insulin pens for current residents which were stored in the fridge and when a new pen was opened, it was dated with the open and expiration date. RN-C further stated if a resident came from a different facility, the procedure was to check for an open date, and if there was not one, to go by the pharmacy dispense date, reporting if the pen was expired from the dispense or open date they would not use the pen.

During interview on 7/28/17, at 11:37 a.m. the director of nursing (DON) stated she was aware of the outdated insulin, further stating insulin should be dated. The DON further stated the nurse managers were going to check the medication carts for outdated insulin going forward.

A facility document entitled Drug Storage Requirements, dated 2011, indicated both Lantus insulin pens expired 28 days after the first use and Novolog insulin pens expired 14 days after first use.

A facility policy entitled Medication Administration, revised 11/10/16, directed staff to date all insulin vials and insulin pens, noting "Stability of drug is maintained for days according to manufacturer when stored at room temperature. Staff should read and be aware of expiration dates after opening."

DESTRUCTION OF CONTROLLED SUBSTANCES

During observation of The Suites medication room on 7/25/17, at 5:36 p.m. a large medsafe (a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 431	Continued From page 50	F 431		

secure narcotic destruction bin) was observed in the medication room. The medsafe appeared secure with identical padlocks on the front, one on the top (lock A) and one on the bottom (lock B). RN-E stated discontinued narcotics (controlled substance) of residents were destroyed by placing the medications in the medsafe. RN-E stated the destruction was witnessed with another nurse, RN/licensed practical nurse (LPN) or nurse manager.

During observation of The Gardens medication room on 7/25/17, at 7:14 p.m. a smaller medsafe was observed in the medication room and also appeared secure with two identical padlocks, the same as the medsafe on The Suites. LPN-E also stated that medsafe was used for discontinued narcotics such as Fentanyl patches (narcotic pain patch) and the destruction had to be witnessed by another nurse.

During interview on 7/27/17, at 1:02 p.m. RN-D stated she had keys to the medsafe, and RN-F also had keys to the other medsafe. RN-D reported staff disposed of both controlled and non controlled substances in the medsafe, and that she had access to those medications with the keys via the padlocks on the front of the medsafe. RN-D stated staff signed a facility narcotic destruction record when they disposed of controlled substances in the medsafe. During interview, RN-D was observed to pull the medsafe keys out of an unlocked desk drawer in her office. RN-D acknowledged she stored the keys in the unlocked drawer, but always kept her office door locked and shut when unattended. RN-D was then observed to use her keys to open the medication room and subsequently use the keys to open both padlocks on the medsafe.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 431	Continued From page 51	F 431		

RN-D pulled out the inner box from the medsafe which was observed open, and verified on the top of the inner box were loose pills and a package of oxycodone 5 mg tablets.

During continuous observation on 7/27/17, from 2:00 p.m. to 2:24 p.m. RN-F's office door remained open, while RN-F was out of her office and in a resident's room. During observation three unidentified staff were at the nurses station near RN-F's office and one resident went by RN-F's office.

During interview on 7/27/17, at 2:26 p.m. RN-F stated she had keys to the medsafe on the floor. During interview RN-F was observed to take the keys out of an unlocked desk drawer in her office. RN-F proceeded to open both padlocks of the medsafe and pull out the inner box, which was open, and verified there were loose pills inside the box. RN-F verified the keys had been stored in the unlocked desk drawer while her office door was open and left unattended, but further stated she normally did not leave her office door open and normally kept the keys on her, not in the drawer. RN-F acknowledged there was no reconciliation done when the inner boxes with loose pills were picked up.

During interview on 7/28/17, at 10:46 a.m. the Sharps compliance senior director stated medsafe was designed so the facility would have keys to padlock A and the pharmacy would have keys to padlock B, so in order to remove the inside container for disposal. He further stated if one person had the keys to both padlocks, there is potential for diversion and the pharmacy should have been aware they were suppose to have one set of these keys.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 431	Continued From page 52	F 431		

During interview on 7/28/17, at 11:37 a.m. the DON stated RN-D and RN-F had locks put on their office drawers. The DON re-enforced the facility had only had the medsafe for a couple of months and thought it was "much cleaner" way of disposing of controlled substances. The DON further stated nothing on earth was a fail safe against diversion and thought they had really good controls in place.

Review of the facility's Certificate Of The Inventory And Destruction Of Controlled Substances Form: Long-Term Care Faculties, reviewed from 5/1/17 to 7/27/17, identified the following controlled substances, either in packaging or as free pills, had been disposed of and was currently in the medsafe's:
- Tramadol (pain reliever)15 tablets
- Oxycontin (pain reliever) 31 tablets
- Oxycodone IR (instant release) (pain reliever) 33 tablets
- hydrocodone-acetaminophen (pain reliever) 143 tablets
- acetaminophen-codeine (pain reliever) 15 tablets
- Ultracet (pain reliever) 11 tablets
- Fentanyl Patch (pain reliever) 7 patches
- hydromorphone (pain reliever) 9 tablets
- Percocet (pain reliever) 28 tablets
- Ativan (anti-anxiety medication) 13 tablets and 102.75 ml (milliliters)
- Xanax (anti-anxiety medication) 31 tablets
- clonazepam (tranquilizer) 33.5 tablets
- morphine (pain reliever) 65 tablets and 366.72 ml

Medsafe manufacturer's instructions from Sharps Compliance Incorporated, undated, indicated the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 431	Continued From page 53	F 431		

system was used for controlled and non controlled substances. It further directed one pharmacy employee and one authorized supervisor level long term care employee would each have a set of keys to the medsafe. The instructions did not address where or how to store the keys.

No other policies were provided.

STORAGE OF CONTROLLED SUBSTANCES

R34's Resident Face Sheet identified a diagnosis of anxiety.

R34's current physician orders identified an order for lorazepam (an anti-anxiety medication) 0.5 mg in the morning and at night as needed. R34's MAR, from 6/1/17-7/26/17, indicated he had taken lorazepam once during the last two months.

During observation of the Main Street medication cart on 7/24/17, at 12:17 p.m. R34's package of lorazepam tablets was observed and counted against the controlled substance bound registrar, which recorded six tablets of lorazepam. R34's lorazepam package was observed with five whole tablets and the sixth tablet, which was circled with a black permanent marker, was broken into pieces, two larger pieces could be observed. The back of the package, right behind the broken pill, was taped and clear top of the pack, the part over the pill, was crushed.

During interview on 7/24/17, at 12:17 p.m. RN-B stated pieces of the pill could still be observed through the clear plastic front, so they kept the pill in the package, and continued to count it. RN-B was not aware why or how the pill was broken,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 431	Continued From page 54	F 431		

but stated they would tape the back shut so the pill was not administered.

During observation on 7/25/17, at 6:34 p.m. R34's lorazepam package still contained the broken pill and tape. LPN-B stated the pill was probably broken when try to push it out of the package, further stating the backing on the packages could get worn by pulling them in and out of the medication cart, which could puncture the back, and need the tape. LPN-B stated they "probably should just destroy it," stating R34 might be administered it if not destroyed. LPN-B reported "I wouldn't give it."

During interview on 7/26/17, 11:06 a.m. pharmacy consultant (PC) stated if a whole tablet was coming out a package due to wear and tear, it would be okay for the facility to place tape over the back of the package. PC observed R34's lorazepam stating she did not think there was a potential for diversion, as the other half of the tablet could be observed; however, would recommend destroying it since the tablet was broken.

During interview on 7/26/17, at 2:36 p.m. RN-C stated the backs of packaging sometimes ripped from wear and had to be re-enforced with tape, further stating the pharmacist had made no recommendation against that unless a pill had popped completely out of the packaging, then it would be destroyed. RN-C stated the potential for diversion would depend on how crushed or broken the pill was, further stating the facility had had an incident of diversion in November, but had not had any suspicions since.

During interview on 7/28/17, at 11:37 a.m. the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 431	Continued From page 55 DON stated the facility had had a suspected diversion "a couple years ago," and thought things were going well with controlled substance storage now. The DON stated she had talked with the consultant pharmacist, who stated it was okay to place tape behind the tablets; however, going forward they would just destroy broken tablets of controlled substances. A facility policy entitled Controlled Drug Policy and Procedure, revised 7/26/17, directed "In counting controlled drugs, the nurse must be alert for any evidence of substitution or tampering. Inspect tablets and solutions closely, noting any defects in drug containers." It further directed any suspicion of tampering would be reported to the DON or nurse manager.	F 431		
F 441 SS=F	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not	F 441		9/5/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 441	Continued From page 56 limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store,	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 441	Continued From page 57 process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure ongoing infection control surveillance included tracking, trending and infection prevention measures based on identified infectious trends and failed to implement a program to prevent Legionella in the facility water systems to prevent an outbreak of Legionnaires' Disease. This had the potential to effect all 71 residents residing in the facility, visitors, and staff. In addition, the facility failed to ensure appropriate hand hygiene was followed for 2 of 2 residents (R68, R25) observed during blood glucose monitoring. INFECTION CONTROL SURVEILLANCE On 7/28/17, at 12:04 p.m. the infection preventionist, registered nurse (RN)-D was interviewed and stated she was responsible for the infection control prevention and surveillance program. RN-D explained she had taken over the program in June and had not had formal training for the infection control role yet. RN-D reported infections were not tracked in real time as they occurred and explained the logs were completed at the end of the month after obtaining antibiotic usage report from the pharmacy and the infection report from the electronic health record system. RN-D indicated symptoms of illnesses not treated with antibiotics were brought up during the	F 441	INFECTION CONTROL SURVEILLANCE Reported infections were not being tracked in real time as they occurred. All residents would be considered to be at risk for the spread of non-treated infections that are not tracked on daily basis. Infection control log updated by Infection control nurse on 8/9/17/ Infection control nurse will track non-treated infections on daily basis when discussed at daily morning clinical meeting, along with treated infections, and will identify any trends or patterns monthly and for bi-monthly QAPI. The results of the logs will be reviewed at QAPI. Corrective action is ongoing. DON is responsible. LEGIONNAIRE'S Facility has developed policy for water management plan to reduce the risk of Legionella. Team has developed risk assessment related to Legionella and implemented a water management program that may include control measures, such as, physical controls, temperature management, disinfectant	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 441	Continued From page 58 morning interdisciplinary team meetings, however, were not continuously monitored to detect spread of illnesses in order to implement possible prevention and control measures. The infection control logs from January through June 2017, were reviewed with RN-D; RN-D stated documentation lacked identification of infectious trends and lacked documentation of prevention measures based on those infections trends. RN-D explained if there was an increase or pattern of infection type, documentation should have reflected what was done to identify the cause of the pattern or increase and measures to prevent further spread and reoccurrence. The facility's monthly infection control logs were reviewed from January through June 2017 and indicated the following: -All the monthly logs lacked documentation of investigations of infections and/or possible trends, and the corrective actions utilized for prevention of spread or re-occurrence of infections. -January's log indicated eight infections, five were identified as health care associated (HAI). The log reflected three urinary tract infection, one upper respiratory infection (URI), and one skin infection. -February's log indicated 13 infections, 12 were identified as HAIs. The log reflected seven UTIs, two URIs, and two skin infections. -March's log indicated 19 infections, 17 of them were identified as HAIs. The log reflected two catheter associated UTIs, four UTIs, one URI, four lower respiratory tract infections (LRI) and five skin.	F 441	level control, visual inspections an environmental tests. The corrective action has the potential to affect all residents. No cases of health-care-associated pneumonia known or reported for residents. Team will continue to meet ongoing, and report monitoring plan to QAPI committee. Administrator responsible. HAND HYGIENE Resident 25 has shown no ill effects related to improper hand washing procedure. a) No resident was affected by the deficient practice. b) All residents would be considered at risk related to the deficient practice. c) All nursing staff will repeat infection control in-service including hand washing on or before 9/5/17. During new employee orientation, including staff from agency, will be checked off by staff development coordinator on correct hand washing technique and times where hands need to be washed or sanitized. For one month, RN managers and staff development coordinator will each complete 5 audits of nursing staff for understanding of hand washing and return	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 441	Continued From page 59 -April's log indicated 10 infections, eight were identified as HAIs. The log reflected five UTIs, one URI, and three skin infections. -May's log indicated 15 infections, 10 were identified as HAI. The log reflected seven UTIs, one LRI, four skin infections and three pneumonia cases. -June's log indicated 10 infections, nine of them were identified as HAI. The log reflected six UTIs and one skin infection. -July- no log had been initiated. On 7/28/17, at 9:33 a.m. director of nursing (DON) explained RN-D had recently taken over the infection control program. DON stated an awareness the program was lacking, there was a need for improvement, and explained RN-D was in the process of improving it. DON reported illnesses and infection were discussed during morning meetings, the infection control log should be kept up as infections were identified, and culture reports should be reviewed as they are returned. The facility's Infection Control Program policy dated 2010, indicated the facility would investigate, control, and prevent infections, and would maintain record of incidents and corrective actions related to infections. LEGIONNAIRE'S (a type of pneumonia caused by legionella bacteria) When interviewed on 7/24/17, at 9:10 a.m.	F 441	demonstration. During next month, each will audit 3 staff for understanding of hand washing and return demonstration. DON will report outcome of audits at QAPI and it will be determined whether to continue audits at that time. Corrective action will be complete 9/5/2017 DON responsible.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 441	Continued From page 60	F 441		

director of maintenance (DOM) stated the facility had "no features that would lend to give off Legionnaires' Disease."

When interviewed on 7/28/17, at 8:21 a.m. director of nursing (DON) stated there was no policy in place for Legionnaire's disease. After talking with DOM, his understanding was where there are "pipe-ins" is where it can grow.

When interviewed on 7/28/17, at 8:57 a.m. administrator stated there was no facility policy for Legionnaire's disease, and the facility has not conducted a facility risk assessment to identify where waterborne pathogens could grow and spread in the water system.

HAND HYGIENE

R68's quarterly Minimum Data Set (MDS), dated 6/30/17, identified R68 had moderate cognitive impairment and required extensive assistance with activities of daily living (ADLs). R68's resident face sheet, dated 1/26/17, identified diagnoses including diabetes mellitus.

R68's Diabetic Administration History, dated 7/1/17 to 7/26/17, indicated blood glucose monitoring four times daily, including before meals and at bedtime.

R25's annual MDS, dated 6/12/17, identified R25 had moderate cognitive impairment and required extensive assistance for most ADLs. R25's resident face sheet, dated 5/2/17, included diabetes mellitus, MRSA (methicillin resistant staph aureus) (bacteria that is resistant to certain antibiotics) infection, atonic (lacking muscular

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 441	Continued From page 61	F 441		

tone) urinary bladder, and had an indwelling Foley catheter.

R25's physician order report, dated 7/28/17, included glucometer monitoring four times per day, including before meals and at bedtime.

R25's Nursing Home Rounds, dated 6/8/17, identified R25 was treated with a course of antibiotics for MRSA urine infection and indicated, "Unfortunately, he is at high risk for recurrence given the indwelling Foley catheter."

During continuous observation on 7/26/17, at 11:43 a.m. registered nurse (RN)-A entered R68's room with a small plastic basket that contained supplies needed to check his blood sugar, as well as R68's personal glucometer. RN-A placed the basket on R68's bed, and donned gloves. RN-A placed a test strip into the glucometer, cleaned R68's finger with an alcohol pad, poked his finger with a lancet, wiped a drop of blood with a cotton ball, squeezed his finger and placed a drop of blood onto the test strip. RN-A placed the used lancet into the sharps container in the basket, removed her gloves and threw them in the waste basket in the room. Without completing hand hygiene, RN-A picked up the basket and left R68's room. RN-A walked in the hallway to the medication cart, placed the basket on top of the medication cart and used a disposable wipe to clean the surface of the glucometer, however, did not complete hand hygiene. RN-A opened the drawer to another medication cart, and placed R68's glucometer in the drawer. RN-A picked up another glucometer out of the medication cart drawer, grabbed the small plastic basket, and proceeded to R25's room. Outside of R25's room, without performing hand hygiene, RN-A donned a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 441	Continued From page 62	F 441		

yellow disposable gown and gloves, and stated R25 had isolation precautions due to "MRSA [methicillin resistant staph aureus] [bacteria that is resistant to certain antibiotics] in his urine." RN-A entered R25's room and set the plastic basket on R25's bed, without a barrier to prevent cross contamination. RN-A cleaned R25's finger with an alcohol pad and poked his finger, wiped the first drop of blood with a cotton ball, and placed a drop of blood onto the test strip in the glucometer. RN-A threw the lancet into the sharps container in the plastic basket, used her soiled gloved hand to untie the strings of the disposable gown on the back of her neck, removed the gown, and threw it into the waste basket. RN-A then removed the soiled gloves, and without performing hand hygiene, used a disposable wipe containing 70% isopropyl alcohol, instead of an Environmental Protection Agency (EPA)-registered disinfectant (recommended by the Center for Disease Control to kill MRSA), to clean the surface of the glucometer and the bottom of the basket. Still without performing hand hygiene, RN-A walked into the hallway carrying the basket with supplies in her left hand. RN-A used the hand sanitizer dispenser on the cart outside of R25's room to pump sanitizing liquid into her right hand, and walked in the hallway to the medication cart with her right hand closed. Without rubbing her hands together to perform hand hygiene, RN-A used her right hand to open the medication cart drawer and placed R25's glucometer into the drawer. Still without performing hand hygiene, RN-A placed the basket with supplies onto the medication cart and prepared to administer insulin to another resident. RN-A was asked by the surveyor to stop and to perform hand hygiene.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 441	Continued From page 63	F 441		

When interviewed on 7/26/17, at 12:03 p.m. RN-A indicated she didn't usually perform hand hygiene before leaving a resident's room, but would usually come back to the medication cart and use the hand wipes to sanitize her hands. RN-A stated, "I haven't touched blood or anything, but it's a double check." RN-A stated, "It's not like a hospital. They want the nursing home to be more home-like, not institutionalized." When asked about R25's diagnosis of MRSA and isolation precautions, RN-A stated, "It's for MRSA, not C-diff [bacteria causing diarrhea] or something like that that I'd have to wash for."

During an interview on 7/27/17, at 4:59 p.m. DON stated hand hygiene should be performed after completing a glucometer reading, when removing gloves, and between residents, and stated, "I would prefer that all staff wash their hands or sanitize before leaving the [resident's] room." When asked about infection control procedures for a resident with MRSA, the DON referred to the facility policy, then stated staff should be using the disinfectant wipes in the "purple top" (EPA-registered disinfectant product approved to kill MSRA bacteria). The DON stated staff should use a barrier when setting equipment on the resident's bed, and went on to describe doffing of personal protective equipment (PPE), indicating she would remove the disposable gown first, and then remove the gloves. The DON stated, "I go out on the floor and watch. If I see issues, I deal with it."

Review of the facility's policy, Hand Hygiene, dated 2010, directed, "Hand hygiene must be performed after touching blood, body fluids, secretions, excretions, and contaminated items, whether or not gloves are worn; immediately after

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

(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) COMPLETION DATE
F 441	Continued From page 64 gloves are removed; and when otherwise indicated to avoid transfer of microorganisms to other residents, personnel, equipment and/or the environment," with specific examples including after removing gloves and after caring for a resident with an active infection. Review of the facility's policy, Standard Precautions, dated 2010, under Removing PPE, identified, "Outside of gloves are contaminated!" The policy directed removing gloves, then goggles or face shield, then gown, then mask. The policy further directed, "Perform hand hygiene immediately after removing all PPE." The policy also identified, under Care of the Environment, "Use EPA-registered disinfectants that have microbial (i.e., killing) activity against the pathogens most likely to contaminate the patient-care environment."	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/26/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	**230 CHURCH AVENUE, BOX 676** **ALBANY, MN 56307**

(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) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department Of Public Safety, State Fire Marshal Division on uly 26,2017. At the time of this survey, Mother Of Mercy Campus Of Care was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/17/2017

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/26/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	**230 CHURCH AVENUE, BOX 676** **ALBANY, MN 56307**

(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) COMPLETION DATE
K 000	Continued From page 1	K 000		

Or by e-mail to:
Marian.Whitney@state.mn.us and
Angela.Kappenman@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

Mother Of Mercy Campus Of Care is a 3 story building with no basement. The building was constructed at 3 different times. The original building was constructed in 1983 and was determined to be of Type II(222) construction. In 1999, an addition (Welcome Room) was added to the east that was determined to be of Type V(111) construction. In 2009 the 3rd floor addition was added to the facility above the existing 1983 building and was was determined to be of Type II (111) construction. The 3 buildings have a 2 hour fire separation between the 1983, 1999, and 2009 buildings and additions and the entire facility was downgraded to Type II (111) construction. The facility was surveyed as one facility.

The building is fully sprinkler protected and the sprinkler system is installed in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems. The facility has a manual fire alarm system with corridor smoke detection and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/26/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	**230 CHURCH AVENUE, BOX 676** **ALBANY, MN 56307**

(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) COMPLETION DATE
K 000	Continued From page 2 smoke detection in spaces open to the corridors. The system is monitored for automatic fire department notification and installed in accordance with NFPA 72 "The National Fire Alarm Code". The facility has a licensed capacity of 73 and had a census of 70 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 920 SS=C	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5	K 920		8/17/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/26/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY SENIOR LIVING	**230 CHURCH AVENUE, BOX 676** **ALBANY, MN 56307**

(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) COMPLETION DATE
K 920	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure a multiple outlet connection was in accordance with the 2012 edition of NFPA 99 section 10.2.3.6 item 2 for total ampacity. This deficient practice could cause an overload of a circuit which could cause a power outage to necessary equipment or cause a fire. This could affect an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am and 1:00pm on 07/26/2017, observations and staff interview revealed: 1) In room 364 medical equipment plugged into an unapproved powerstrip and an extension cord plugged into that power strip. 2) In room 251 an extension cord was plugged into the wall. This deficient condition was confirmed by the Facility Maintenance Director.	K 920	1) Environmental services staff inspected all resident rooms for the use of unapproved power cords/extension cords, which were removed. Power cords that meet UL 1363 will be used, as needed in resident rooms. Environmental services will inspect resident rooms annually to ensure compliance. Families will be sent notice to inform on unapproved power cord/extension cord use annually. 2) 8/14/2017 3) Ron Zierden, Environmental Services Director will be responsible for correction and monitoring to prevent a reoccurrence of K920.	