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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: DD7U

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 CAMPUS OF CARE**
(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 **09/03/2014** (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 **76** (L18)

13.Total Certified Beds **76** (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
	76			
(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 09/18/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist 09/18/2014 (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 10/24/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/16/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245339

September 18, 2014

Mr. Dean McDevitt, Administrator
Mother Of Mercy, Campus Of Care
230 Church Avenue, Box 676
Albany, Minnesota 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 3, 2014 the above facility is certified for or recommended for:

76 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 76 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
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
September 18, 2014

Mr. Dean McDevitt, Administrator
Mother Of Mercy, Campus Of Care
230 Church Avenue, Box 676
Albany, Minnesota 56307

RE: Project Number S5339023

Dear Mr. McDevitt:

On August 6, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 24, 2014. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On September 3, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 24, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 3, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 24, 2014, effective September 3, 2014 and therefore remedies outlined in our letter to you dated August 6, 2014, will not be imposed.

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
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245339	A. Building B. Wing	9/3/2014

Name of Facility	Street Address, City, State, Zip Code
MOTHER OF MERCY CAMPUS OF CARE	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0157** Reg. # **483.10(b)(11)** LSC	Correction Completed **09/03/2014**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **09/03/2014**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **09/03/2014**
ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **09/03/2014**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **09/03/2014**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **09/03/2014**
ID Prefix **F0411** Reg. # **483.55(a)** LSC	Correction Completed **09/03/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	JS/KJ	09/18/2014	32209	09/03/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
7/24/2014			

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00634	A. Building B. Wing	9/3/2014

Name of Facility	Street Address, City, State, Zip Code
MOTHER OF MERCY CAMPUS OF CARE	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20265** Reg. # **MN Rule 4658.0085** LSC	Correction Completed **09/03/2014**	ID Prefix **20560** Reg. # **MN Rule 4658.0405 Subp. 2** LSC	Correction Completed **09/03/2014**	ID Prefix **20830** Reg. # **MN Rule 4658.0520 Subp. 1** LSC	Correction Completed **09/03/2014**
ID Prefix **20855** Reg. # **MN Rule 4658.0520 Subp. 2 E.** LSC	Correction Completed **09/03/2014**	ID Prefix **20900** Reg. # **MN Rule 4658.0525 Subp. 3** LSC	Correction Completed **09/03/2014**	ID Prefix **21330** Reg. # **MN Rule 4658.0725 Subp. 2 A&** LSC	Correction Completed **09/03/2014**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	JS/KJ	09/18/2014	32209	09/03/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
7/24/2014			

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
September 18, 2014

Mr. Dean McDevitt, Administrator
Mother Of Mercy Campus Of Care
230 Church Avenue, Box 676
Albany, Minnesota 56307

Re: Reinspection Results - Project Number S5339023

Dear Mr. McDevitt:

On September 3, 2014 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 3, 2014. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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.

Please feel free to call me with any questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: DD7U

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 CAMPUS OF CARE**
(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 **07/24/2014** (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 **76** (L18)

13.Total Certified Beds **76** (L17)

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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	76			
(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 :
Holly Kranz, HFE NE II — 08/19/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 09/11/2014 (L20)

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

19. DETERMINATION OF ELIGIBILITY
_____ 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 09/16/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
August 6, 2014

Mr. Dean McDevitt, Administrator
Mother Of Mercy Campus Of Care
230 Church Avenue, Box 676
Albany, Minnesota 56307

RE: Project Number S5339023

Dear Mr. McDevitt:

On July 24, 2014, 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. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

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

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 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:

Jessica Sellner, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7365
Fax: (320)223-7365

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 2, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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 remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

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

Failure to submit an acceptable ePoC 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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. 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 the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 Post Certification Revisit (PCR) 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 remedies will not be imposed. 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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 24, 2014 (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 24, 2015 (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
Division of Compliance Monitoring

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 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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
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 _____	07/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY CAMPUS OF CARE	**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 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic 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 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a	F 157		8/27/14

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

Electronically Signed | 08/16/2014

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.

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	245339	A. BUILDING _____ B. WING _____	07/24/2014

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F 157	Continued From page 1 change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the physician of a decline in pressure ulcer condition from a stage I to a stage II, for 1 of 1 residents (R93) reviewed for worsening pressure ulcers. Findings include: R93 was admitted to the facility on 06/03/2014. R93's admission diagnoses on the face sheet dated 7/24/14, included hip joint replacement, edema, and osteoporosis. R93's admission Minimum Data Set (MDS) dated 6/10/14, identified R93 had one stage I pressure ulcer present, defined as intact skin with non-blanchable redness of a localized area. R93's Body Audit dated 6/10/14, identified a reddened area in the left gluteal cleft. R93's nursing progress notes dated 6/27/14, indicated R93 developed an open area on the right lateral buttock near the coccyx. The progress note indicated the area was approximately 1.3 cm x 2 cm (centimeters) and was being covered with protective ointment.	F 157	R 93□s nursing progress note and the Non-Pressure Skin Condition Report dated 6/27/2014 in the clinical record was amended on 8/8/2014 to reflect physician notification related to the decline in the pressure ulcer condition from a stage I to a stage II per the LPN who worked on that date. R 93□s primary care physician (PCP) completed a physical assessment on 8/5/2014 when he came to see R93 for a follow up visit and no further orders were noted as the pressure ulcer has now healed. Audits were completed immediately on 7/23/2014 to ensure notification was completedand for all residents who were identified with skin conditions present. No additional resident□s were identified to be affected. Measures put into place include In-service training for all licensed and unlicensed nursing staff completed by the DON and the Staff Development RN on 8/13 & 8/14/14. The in-service training included practices as it relates to notification of residents, their legal representative and	

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F 157	Continued From page 2 R93's Non-Pressure Skin Condition Report dated 6/27/14, identified an open area in the right buttock crease near the coccyx that was 1.3 cm x 2.0 cm, with a red wound bed and surrounding skin. The surrounding wound edges and tissue were described as irregular/white. An Allevyn (a type of adhesive foam dressing) was applied. The document had a section to indicate whether R93's practitioner was notified of the wound, which was blank. The clinical record lacked evidence the physician was notified of the open pressure ulcer after it developed on 6/27/14. During interview on 7/23/14, at 8:33 a.m. registered nurse (RN)-B stated R93's open area was now a stage II pressure ulcer, defined as partial thickness loss of dermis presenting as a shallow open ulcer with a red/ pink wound bed, without slough, which had worsened since admission. During another interview on 7/24/14, at 10:20 a.m. RN-B was unable to locate any information regarding the physician being notified of the decline in R93's pressure ulcer. RN-B stated this would be documented in the progress notes, however, R93's progress notes had no information related to the physician being notified. During interview on 7/24/14, at 10:40 a.m. the director of nursing (DON) stated the size and condition of a pressure ulcer would be documented on a weekly basis by an RN, and if a pressure ulcer worsened or was not healing with current skin interventions the physician would be notified. The facility's policy titled Standing Orders for	F 157	their PCP whenever there is a significant change in condition such as a decline in a pressure ulcer condition. The in-service attendance records will be reviewed by the staff development RN and/or her designee twice a week beginning 8/18/2014. Any nursing staff that did not attend the scheduled in-service will complete the training by 8/27/14. Daily audits of the 24 hour clinical report tool nursing staff use to document notification of condition changes will begin on 8/18/2014 M-F by the DON and/or her designee during the IDT clinical meeting. Daily audits of the wound documentation records will be completed beginning 8/18/2014 by the DON and/or her designee to ensure notification of changes in wounds has been completed. The DON and/or her designee will review the audits weekly times 4 weeks, then monthly times 2 months and at least quarterly to evaluate that the corrective action is achieved and sustained. Audit results will be reviewed with the QA Committee at their regular scheduled meetings. If negative trends are identified, the QA Committee will direct further interventions to assure that compliance is achieved and maintained.QA meeting are held at least quarterly unless more frequent meetings are necessary because of audit results showing negative trends. The next QA meeting will be on August 28, 2014.	

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F 157	Continued From page 3 Wounds and Skin Care Protocols dated 4/12/12, indicated the MD (medical doctor) / NP (nurse practitioner) will be notified of all new wounds, significant changes, and non-healing wounds.	F 157		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop a care plan to address prevention of skin breakdown for 1 of 3 residents, (R93) reviewed for worsening pressure ulcers. In addition, the facility failed to ensure the care plan was developed to include specific oral hygiene needs for 1 of 1 residents (R1) reviewed	F 279	R 93□s Care plan and resident information sheet (RIS) was updated on 7/23/2014 to address the interventions being utilized to prevent further skin breakdown which included turning and repositioning needs. The pressure ulcer was completely healed on 8/1/2014 and	8/27/14

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F 279	Continued From page 4 for dental services. Findings include: R93 was admitted to the facility on 06/03/2014. R93's admission diagnoses according to the face sheet dated 7/24/14, included a hip joint replacement status, urge incontinence, edema, and osteoporosis. R93's admission Minimum Data Set (MDS) dated 6/10/14, identified R93 had one stage I pressure ulcer present, defined as intact skin with non-blanchable redness of a localized area. R93's Body Audit dated 6/10/14, identified a reddened area in the left gluteal cleft. R93's Care Area Assessment dated 6/16/14, indicated R93 was at risk for developing pressure sores due to limited mobility, was chairfast, and had a reddened coccyx with no open areas. R93's Care Plan dated 6/3/14, identified R93 received barrier cream and was an assist of two staff with transfers. The care plan did not instruct staff on a turning and repositioning schedule for R93, where the barrier cream was to be applied, and did not identify the current pressure ulcer or interventions to ensure healing. In addition, the pressure ulcer worsened and the care plan did not address additional interventions to promote healing nor did it identify if the interventions had been reassessed to promote healing. R93's nursing progress notes dated 6/27/14, indicated R93 developed an open area on the right lateral buttock near the coccyx which was approximately 1.3 c.m. x 2 cm (centimeters). The note indicated protective ointment was to be	F 279	remains healed at this time. Skin breakdown audits were completed on 8/8/14 for all residents currently identified with skin conditions. All five residents identified at risk to decline were found to have a comprehensive care plan in place that addresses prevention of skin breakdown. Facility wide audits were started on 8/8/14 and completed on 8/15/14 utilizing the Bath audit tool for every resident. Twelve residents were identified at risk and their care plans were reviewed and address prevention of skin breakdown. No other residents were identified to be affected. R1□s care plan and RIS was updated on 8/8/2014 to address specific oral hygiene needs. The DON spoke to the local dentist on 8/11/2014 to schedule an appointment. The dentist stated he would contact DON the week beginning on 8/18/2014 to schedule a time he could come to the facility instead of making arrangements to transport R1 to his office. R1□s family member was notified on 8/11/14 of the upcoming dental visit, (date to be determined) and is in agreement to this plan. Measures put into place included a review and revision of the facility oral hygiene policies and procedures on 8/13/2014, (see attachments). In-service training for all licensed and unlicensed nursing staff was completed by the DON and the Staff Development RN on 8/13 & 8/14/14. The in-service training included communication of the care plan interventions utilizing the RIS for the direct care staff to utilize and care plan	

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F 279	Continued From page 5 applied. R93's Non-Pressure Skin Condition Report dated 6/27/14, identified an open area in the right buttock crease near the coccyx that was 1.3 cm x 2.0 cm, with a red wound bed and surrounding skin. The surrounding wound edges and tissue was irregular/white. An Allevyn (a type of adhesive foam dressing) was applied. The description of the pressure ulcer indicated it was currently a stage II, defined as partial thickness loss of dermis presenting as a shallow open ulcer with a red/ pink wound bed, without slough. During observation on 7/22/14, at 3:34 p.m. R93 was seated in her recliner chair watching TV. R93 said she thought she still had some sore areas on her bottom and was unsure of how long they had been there. During observation on 7/23/14, at 8:10 a.m. R93 had an Allevyn dressing covering her coccyx area, which had a date written on it of 7/23/14. During interview at this time, nursing assistant (NA)-C stated staff used a shift report book and the 24-hour shift reports to obtain resident information. NA-C stated R93 was toileted every two hours, but was unsure how often the resident needed to be repositioned. NA-C stated there was a nursing assistant worksheet which contained instructions about the resident. R93's Resident Information Sheet - West (a nursing assistant care guide/worksheet) was reviewed and did not instruct staff on how often R93 required assistance with turning or repositioning. The worksheet identified R93's coccyx was not blanchable and she used EPC (emollient protective cream).	F 279	development to address prevention of skin breakdown. The in-service included a review of the Skin Integrity program and the wound and skin care protocols. The oral hygiene policy and procedure for the conscious and unconscious resident and the standards of practice as it relates to oral hygiene needs were included in the in-service. A new SAGE product line was introduced and reviewed as it relates to oral hygiene. The in-service attendance records will be reviewed by the staff development RN and/or her designee twice a week beginning 8/18/2014. Any nursing staff that did not attend the scheduled in-service will complete the training by 8/27/14. The DON and/or her designee started facility wide audits on 7/31 which will be completed no later than by 8/20/14 in order to identify other residents having the potential to be affected. Any resident identified at risk will have their care plan and RIS updated to address the specific oral hygiene needs. Audits will be completed by the DON and/or her designee for all new admissions and random audits for ten percent of current residents weekly for 4 weeks to ensure compliance is achieved as it relates to care planning. The DON and/or her designee will review the audits weekly times 4 weeks, then monthly times 2 months and at least quarterly to evaluate that the corrective action is achieved and sustained. Audit results will be reviewed with the QA Committee at their regular scheduled meetings. If negative trends are identified, the QA	

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F 279	Continued From page 6 During interview on 7/23/14, at 8:33 a.m. registered nurse (RN)-B stated a turning and repositioning program was not defined on R93's are plan and staff missed documenting care plan interventions for R93's current stage II pressure ulcer. R1's quarterly MDS dated 6/17/14, indicated R1 was comatose and totally dependent on staff for all activities of daily living (including personal hygiene and oral care). R1's care plan dated 10/14/06, identified a problem with personal hygiene due to persistent vegetative state related to traumatic brain injury. The approaches included R1 needed and received total assist of one to two staff for personal hygiene, and staff were to notify a nurse with any changes or concerns. Oral hygiene was not addressed on R1's care plan. R1's Nursing Assistant Care Sheet dated 7/22/14, did not instruct staff on R1's specific oral care/hygiene needs. During interview on 7/21/14, at 3:39 p.m. R1's family member (FM)-A stated she came to the facility on almost a daily basis, and had never seen staff brush R1's teeth. She stated staff occasionally wiped R1's mouth with a pink toothette, however, this was not done on a daily basis. She stated R1 had two toothbrushes available which staff could use and were located in the medicine cabinet in R1's bathroom. Both toothbrushes and the basin they were stored in were dry. One of the toothbrushes was battery-operated and was nonfunctioning.	F 279	Committee will direct further interventions to assure that compliance is achieved and maintained.QA meeting are held at least quarterly unless more frequent meetings are necessary because of audit results showing negative trends. The next QA meeting will be on August 28, 2014.	

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F 279	Continued From page 7 Observation of personal cares for R1 on 7/23/14, at 8:14 a.m. were being provided by NA-A and NA-B, and no oral cares were observed being provided. NA-B stated when she washed R1's face, she wiped his lips and checked his mouth for debris. NA-B stated she was told not to provide oral care to R1 because, "Crusty stuff would appear." NA-A stated she thought because R1 had a tracheostomy, the nursing assistants were not allowed to brush the resident's teeth due to the risk of choking, and staff would need to have a suction machine available and the NA's were not trained to use this machine. During interview on 7/23/14, at 1:52 p.m. RN-B stated oral care should be done on all residents. RN-B stated she would expect the NA's to brush R1's teeth like every other resident. RN-B stated R1 had a tracheostomy and a suction machine would need to be available. RN-B stated nursing assistants were not trained on the use of a suction machine, so only licensed staff could brush R1's teeth. RN-B stated R1's care plan did not address oral care or who was responsible to ensure the resident was provided oral care on a regular basis. During interview on 7/23/14, at 12:13 p.m. the director of nursing (DON) stated oral cares should be provided to all residents and the care plan should include specific instructions to ensure staff was aware on how to preform it correctly.	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain	F 309		8/27/14

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F 309	Continued From page 8 or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 resident (R1) who was placed on un-needed isolation related to infection, ensured that all staff were educated and aware of /infection status, which resulted in R1 being isolated to his room. Findings include: R1's quarterly Minimum Data Set (MDS) dated 6/17/14, identified R1 was comatose, nonverbal, and totally dependent on staff for all activities of daily living. R1's Care Area Assessments (CAA's) dated 1/2/14, identified R1 was unable to communicate his needs and was totally dependent on staff for all ADLs. R1's care plan dated 10/14/06, identified R1 was on isolation precautions which included gowning, gloving, and masking, related to a history of pseudomonas in sputum. R1 was to wear a mask when he came out of his room, however, the care plan indicated, "Usually does not leave room." Staff were instructed to follow isolation procedures per the facility policy and use contact precautions when providing cares. R1's Nursing Assistant Care Sheet dated 7/22/14,	F 309	R1 has no evidence of symptoms that represent an increased risk for contact transmission related to the sputum results dated 7/4/2014. R1□s isolation status was clarified in the clinical record to reflect standard precaution vs. contact precautions/isolation on 8/5/2014. All isolation materials located in R1□s room such as specific isolation barrels for trash and linens were removed from R1□s room on 8/5/2014. R1□s care plan and RIS were updated on 8/5/2014 to reflect R1□s isolation status was discontinued and activities of interest resident was to attend which take place outside of resident□s room. DON met with R1□s legal representative on 8/16/2014 to review R1□s current plan of care as it relates to infection control. R1□s legal representative is in agreement with plan to have resident attend music and Lutheran services when those activities are offered. R1□s legal representative request R1 continue with his 1:1 room visits currently in place and completed by activity staff three times weekly to stimulate R1□s senses with touch, sound and olfactory interventions. A facility wide audit was completed by DON on 8/5/2014 and no other residents	

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F 309	Continued From page 9 directed nursing assistants to gown, glove and mask in the room and to take pseudomonas precautions (sputum). R1's physician order dated 7/17/14, did not indicate any special isolation or infection control status. The physician order instructed R1 was to have a sputum culture every three months due to pseudomonas infection. The following sputum culture results were located in R1's medical record: 9/27/13- Heavy growth of Pseudomonas fluoresces-putida group. The physican wrote, "Would only treat if having symptoms." Registered nurse (RN)-C documented, "No symptoms; will not treat." 12/19/13- Moderate growth of Pseudomonas fluoresces-putida group. On the sputum culture report an unknown staff wrote, "Symptoms? Increased phlegm, O2 (oxygen) stable, No temp, respirations OK." R1 did not require treatment. 4/5/14- No culture needed to be completed as the initial results came back clear. 7/4/14- Moderate growth of Pseudomonas seruginosa. An unidentified staff wrote, per physician standing order no treatment if not symptomatic. Nursing home stated R1 was not symptomatic. During interview on 7/21/14, at 3:39 p.m. R1's family member (FM)-A stated she did not understand why R1 required special infection control procedures some of the staff implemented (such as gowning, gloving, and masking), and	F 309	were identified to be in isolation or contact precautions. Measures put into place included a review of the facility transmission precautions policies and procedures on 8/5/2014 which meet the CDC isolation guidelines. In-service training for all licensed and unlicensed nursing staff was completed by the DON and the Staff Development RN on 8/13 & 8/14/14 related to the CDC guidelines. The in-service training included a review of standard precaution and transmission precautions which included a review of contact precaution/isolation criteria. Direct observation of the nursing staff providing direct cares to R1 will be done 3 times a week times 4 weeks to ensure that corrective action is achieved and sustained. New nursing staff during orientation will be given the isolation and transmission precautions procedure during the infection control training portion of orientation. The in-service attendance records will be reviewed by the staff development RN and/or her designee twice a week beginning 8/18/2014. Any nursing staff that did not attend the scheduled in-service will complete the training by 8/27/14. Audits will be completed by the DON and/or her designee for all new admissions and random audits for ten percent of current residents weekly for 4 weeks to ensure compliance is achieved as it relates to isolation/infection status. The DON and/or her designee will review the audits weekly times 4 weeks, then monthly times 2 months and at least	

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F 309	Continued From page 10 stated, "There is nothing wrong with him." FM-A stated a couple months ago, a nursing assistant refused to transfer R1 from his bed to his wheelchair so she could take him to the beauty shop for a hair cut. She indicated the nursing assistant went to the beauty shop and had the beautician come to the resident's room for the haircut. FM-A stated she was very angry at the nursing assistant and felt, "It was her right to ensure he (R1) had a hair cut in the beauty shop," just like everyone else. During interview on 7/20/14, at 2:15 p.m. licensed practical nurse (LPN)-A stated she thought R1 was on isolation/ contact precautions for a history of MRSA (Methicllin resistant staph aureus). During interview on 7/23/14, at 8:2 3 a.m. nursing assistant (NA)-A and NA-B stated R1 did not leave his room because of his, "MRSA infection." NA-A stated she had worked with R1 for over three years and had not seen him taken out of his room other than for medical appointments during the last 3 years due to his infectious disease status. During observation on 7/23/14, at 8:50 a.m. LPN-A was administering R1's medication through a G tube (gastrostomy tube). LPN-A was wearing a mask, gloves, and a gown, which she stated she was wearing because of R1's MRSA precautions. During interview on 7/23/14, at 12:13 p.m. director of nursing (DON) stated R1 was currently being isolated due to pseudomonas, however, the resident was not considered to be infectious. During interview on 7/23/14, at 1:52 p.m. RN-C	F 309	quarterly to evaluate that the corrective action is achieved and sustained. Audit results will be reviewed with the QA Committee at their regular scheduled meetings. If negative trends are identified, the QA Committee will direct further interventions to assure that compliance is achieved and maintained.QA meeting are held at least quarterly unless more frequent meetings are necessary because of audit results showing negative trends. The next QA meeting will be on August 28, 2014.	

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	245339	A. BUILDING _____ B. WING _____	07/24/2014

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F 309	Continued From page 11 stated R1 was on contact precautions due to pseudomonas. RN-C stated R1's physician does not determine the need for isolation/infection control precautions and the facility can implement precautions without consultation with the physician. RN-C reported she was aware the facility Infection Control Policy did not require precautions or isolation for a resident with pseudomonas. During interview on 7/23/14, at 1:12 p.m. activity assistant (AA)-A stated the activity staff do activities with R1 daily in his room. AA-A stated she was told R1 could not attend any out of room activities related to his MRSA status. She stated, "about 6 months ago," the activity staff tried to get permission from nursing staff to take R1 outdoors, or outside his room, however, nursing staff told the activity staff that R1 could not come out of his room due to his isolation status. During another interview on 7/23/14, at 2:24 p.m. FM-A stated she wanted R1 to attend activities in a group setting like he had in the past. FM-A stated she used to take R1 to play bingo with the other residents but had been told she could no longer do this related to his infection. FM-A was unable to recall exactly how long R1 had been in his room on isolation, however, she stated R1 has been kept in his room, "for a very long time."	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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.	F 312		8/27/14

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F 312	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure oral care was provided for 1 of 1 residents (R1) reviewed who were totally dependent on staff for oral care. Findings include: R1's quarterly Minimum Data Set (MDS) dated 6/17/14, identified R1 was comatose and totally dependent on staff for all activities of daily life (including personal hygiene, oral care). R1's Care Area Assessments (CAAs) completed on 1/2/14, identified dental and activities of daily living (ADLs) were not triggered areas for staff to address. The CAAs summaries did identify R1 was unable to communicate his needs and was totally dependent on staff for all ADLs. R1's care plan dated 10/14/06, identified a problem with personal hygiene due to persistent vegetative state related to traumatic brain injury, and indicated R1 needed and received total assist of one to two staff for personal hygiene. Staff were to notify a nurse with any changes or concerns. Oral hygiene was not addressed on the care plan. R1's Nursing Assistant Care Sheet dated 7/22/14, did not address oral care/hygiene. During interview on 7/21/14, at 3:39 p.m. R1's family member (FM)-A reported she came to the facility on almost a daily basis and had never seen staff brush R1's teeth. FM-A reported staff	F 312	R1□s care plan and RIS was updated on 8/8/2014 to address specific oral hygiene needs. Licensed staff will provide oral hygiene cares BID utilizing the new SAGE product line outlined in the revised oral hygiene policy and procedure for the unconscious resident, (see attached policy). There are no other residents identified with a tracheotomy. The DON and/or her designee started facility wide audits on 7/31 which will be completed no later than by 8/20/14 in order to identify other residents having the potential to be affected related to their ADL needs. Any resident identified at risk will have their care plan and RIS updated no later than 8/27/2014 to address the specific ADL needs. Measures put into place included a review and revision of the facility oral hygiene policies and procedures on 8/13/2014, (see attachments). In-service training for all licensed and unlicensed nursing staff was completed by the DON and the Staff Development RN on 8/13 & 8/14/14. The in-service training included communication of the care plan interventions utilizing the RIS for the direct care staff to utilize and care plan development to address prevention of skin breakdown. The in-service included a review of the Skin Integrity program and the wound and skin care protocols. The oral hygiene policy and procedure for the	

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F 312	Continued From page 13 occasionally wiped R1's mouth with a pink toothette, however, this was not done on a daily basis. She reported R1 had two toothbrushes in the medicine cabinet. The toothbrushes were in a basin in the medicine cabinet, and both were dry. One of the toothbrushes was battery-operated and was non-functional. During observation of personal cares on 7/23/14, at 8:14 a.m. nursing assistant (NA)-A and NA-B were not observed to perform oral care for R1. NA-B stated when she washed R1's face, she wiped his lips and checked his mouth for debris, which she did not find. NA-B indicated she was told not to provide oral care for R1 because, "Crusty stuff would appear." NA-A stated she thought because R1 had a tracheostomy, the nursing assistants were not allowed to brush his teeth due to risk of choking and staff needed to have a suction machine available and they were not trained to use this machine. During interview on 7/23/14, at 1:52 p.m. registered nurse (RN)-B stated oral cares should be done on all residents and expected the nursing assistants to brush R1's teeth like every other resident. RN-B stated R1 had a tracheostomy and there was a risk for choking, so a suction machine would need to be available. However, nursing assistants were not trained on the use of a suction machine, so only licensed staff could brush R1's teeth. During interview on 7/23/14, at 1:54 p.m. trained medication assistant (TMA)-A stated she occasionally provided personal cares for R1 by wiping his mouth out with a pink toothette. During interview on 7/23/14, at 12:13 p.m. director of nursing (DON) stated she would	F 312	conscious and unconscious resident and the standards of practice as it relates to oral hygiene needs were included in the in-service. A new SAGE product line was introduced and reviewed as it relates to oral hygiene. The licensed staff was in-serviced on completion of BID oral hygiene cares for R1 when providing tracheotomy cares. The in-service attendance records will be reviewed by the staff development RN and/or her designee twice a week beginning 8/18/2014. Any nursing staff that did not attend the scheduled in-service will complete the training by 8/27/14. Direct observation of staff performing oral hygiene will be done at least 3 times a week beginning on 8/18/2014 to ensure compliance is achieved. Audits will be completed by the DON and/or her designee for all new admissions and random audits for ten percent of current residents weekly for 4 weeks to ensure compliance is achieved as it relates to oral hygiene. The DON and/or her designee will review the audits weekly times 4 weeks, then monthly times 2 months and at least quarterly to evaluate that the corrective action is achieved and sustained. Audit results will be reviewed with the QA Committee at their regular scheduled meetings. If negative trends are identified, the QA Committee will direct further interventions to assure that compliance is achieved and maintained.QA meeting are held at least quarterly unless more frequent meetings are necessary because of audit results showing negative trends. The next QA	

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F 312	Continued From page 14 expect oral cares to be provided to all residents at the facility. The facility's policy Oral Hygiene for the Unconscious Resident, dated 2008, instructed staff to brush teeth with the use of a suction machine.	F 312	meeting will be on August 28, 2014.	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility did not ensure 1 of 3 residents (R93) admitted with a stage I pressure ulcer received timely assessment and care plan interventions to prevent the pressure ulcer from worsening. Findings include: R93 was admitted to the facility on 06/03/2014. R93's admission diagnoses according to the face sheet dated 7/24/14, included hip joint replacement, urge incontinence, edema, and osteoporosis. R93's admission Minimum Data Set (MDS) dated 6/10/14, identified R93 had a	F 314	R 93□s Stage II pressure ulcer which during the healing process developed into two smaller areas due to the wound base filling in was reassessed on 7/29/2014 and demonstrated complete healing of the site which measured 0.9 cm X 0.3 cm in size on 7/23/2014. On 7/29/2014 a small open area remained measuring 0.2 cm in diameter. A reassessment of the wound was done on 8/1/2014 with demonstration of complete healing of the pressure ulcer. R 93, her PCP and her family member were notified. Audits were completed immediately on 7/23/2014 to ensure weekly monitoring	8/27/14

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F 314	Continued From page 15 stage I pressure ulcer present, defined as intact skin with non-blanchable redness of a localized area. R93's Body Audit dated 6/10/14, identified a reddened area in the left gluteal cleft. R93's Care Area Assessment dated 6/16/14, identified R93 was at risk of developing pressure ulcers due to limited mobility, was chairfast, and had a reddened coccyx with no open areas. R93's (short term) Care Plan dated 6/3/14, indicated R93 received barrier cream and R93 required an assist of two staff with transfers. The care plan did not identify a turning and repositioning schedule or where the barrier cream was to be applied. R93's comprehensive care plan dated 6/30/14, did not identify R93's pressure current pressure ulcer which had worsened since admission, and lacked any interventions related to ensure healing and prevent further skin breakdown. R93's Braden Scale (a tool utilized for prediction of pressure ulcer risk) score, dated 6/24/14, identified a total score of 17, which indicated the resident was at risk for skin breakdown. R93's nursing progress notes dated 6/27/14, identified R93 developed an open area on the right lateral buttock near the coccyx. The area was approximately 1.3 c.m. x 2 cm (centimeters). The note indicated protective ointment was applied to the area. R93's Non-Pressure Skin Condition Report dated	F 314	was completed for all residents who were identified with skin conditions present. No additional resident s was identified to be affected. Skin breakdown audits were completed on 8/8/14 for all residents currently identified with skin conditions. All five residents identified at risk to decline were found to have assessments and comprehensive care plan in place that addresses prevention of skin breakdown. Facility wide audits were started on 8/8/14 and completed on 8/15/14 utilizing the Bath audit tool for every resident. Twelve residents were identified at risk. Assessments were completed upon discovery and their care plans were reviewed and address prevention of skin breakdown. No other residents were identified to be affected. Measures put into place included In-service training for all licensed and unlicensed nursing staff were completed by the DON and the Staff Development RN on 8/13 & 8/14/14. The in-service training included communication of the care plan interventions utilizing the RIS for the direct care staff to utilize and care plan development to address prevention of skin breakdown. The in-service included a review of the Skin Integrity program and the wound and skin care protocols. Audits will be completed by the DON and/or her designee for all new admissions and random audits for ten percent of current residents weekly for 4 weeks to ensure compliance is achieved as it relates to skin breakdown prevention. The DON and/or her designee will review the audits weekly times 4 weeks, then	

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F 314	Continued From page 16 6/27/14, identified an open area on the right buttock crease near the coccyx that was 1.3 cm x 2.0 cm, with a red wound bed and surrounding skin. The surrounding wound edges and tissue were irregular/white. An Allevyn (a type of adhesive foam dressing) was applied. A Tissue Tolerance Testing form, which was testing done to determine how long a resident was able to tolerate sitting without redness, dated 7/1/14, identified R93's skin color was normal at the two hour mark for sitting and lying positions, and R93 could tolerate a two hour repositioning schedule. A nursing progress note dated 7/21/14, indicated R93 had an open area on right lateral buttock near the coccyx area measuring approximately 1.3 cm x 2 cm. with a red wound bed and the surrounding tissue was also reddened. Allevyn was placed over the open area and protective ointment was applied to reddened buttocks. R93's medical record contained no further monitoring or assessment of the pressure ulcer from when it was first documented on 6/27/14, and 7/21/14. During observation on 7/22/14, at 3:34 p.m. R93 was seated in her recliner chair watching TV. R93 said she still had some sore areas on her bottom, and was unsure how long they had been there. During observation on 7/23/14, at 8:10 a.m. R93 had an Allevyn dressing covering her coccyx area which had a date written on it of 7/23/14. During interview at this time, nursing assistant (NA)-C stated R93 was toileted every two hours, but was	F 314	monthly times 2 months and at least quarterly to evaluate that the corrective action is achieved and sustained. Audit results will be reviewed with the QA Committee at their regular scheduled meetings. If negative trends are identified, the QA Committee will direct further interventions to assure that compliance is achieved and maintained.QA meeting are held at least quarterly unless more frequent meetings are necessary because of audit results showing negative trends. The next QA meeting will be on August 28, 2014.	

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F 314	Continued From page 17	F 314		

unsure how often the resident was to be repositioned. NA-C stated there was a nursing assistant worksheet that contained instructions about the resident. R93's Resident Information Sheet - West (a nursing assistant care guide/worksheet) was reviewed and did not identify a turning or repositioning schedule for R93. The worksheet identified R93's coccyx was not blanchable and she used EPC (extra protective cream).

During interview on 7/23/14, at 8:33 a.m. registered nurse (RN)-B stated R93's pressure ulcers should be measured weekly. RN-B confirmed a turning and repositioning program was not defined for R93 and included on her plan of care. RN-B stated R93's pressure ulcer was a stage II (Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled or sero-sanginous filled blister) pressure ulcer and there was no monitoring of the pressure ulcer from 6/27/14, to 7/21/14.

During another interview on 7/23/14, at 1:46 p.m. RN-B stated R93's pressure ulcer had separated into two smaller areas due to the wound base filling in. Additional wound measurements, dated 7/23/14 were added to R93's Non-Pressure Skin Condition Form and identified two separate open areas, both with a pink wound bed and surrounding skin. The areas measured 0.9 cm x 0.3 cm, and 0.3 cm x 0.2 cm.

During interview on 7/24/14, at 10:40 a.m. the director of nurse (DON) stated staff should be assessing any pressure ulcer at least weekly and documenting the size and condition to ensure

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F 314	Continued From page 18 healing. The facility's policy titled Standing Orders for Wounds and Skin Care Protocols dated 4/12/12, instructed the size and wound status should be documented on a weekly basis.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and documentation review, the facility failed to ensure safety interventions were put in place after a fall to minimize the risk of injury for 1 of 3 residents (R83) reviewed for accidents. Findings include: R83's diagnoses included dementia, degenerative disc disease, and osteoarthrosis. Minimum Data Set (MDS) dated 4/28/14, indicated R83's cognition was severely impaired. A care plan dated 4/28/14 indicated R83 displayed signs of short term memory loss. R83 was independent with ambulation with a wheeled walker and received assistance on occasion with ambulation. A nursing assistant care sheet, undated, indicated R83 had non-skid strips at bed side.	F 323	The non-skid strips were placed at the bedside on the floor in R 83□s room on 7/24/2014. Audits were started on 7/28 and completed on 8/14/2014 for all residents who have fallen in the last ninety days to ensure the fall reduction interventions were put into place. Twenty-seven residents were identified at risk. All identified residents had their fall prevention interventions in place as care planned. On 8/12/2014 all twenty-seven residents who have had falls in the last ninety days were reviewed at the resident fall committee meeting to review root cause analysis and discuss fall prevention interventions. No other resident was	8/27/14

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F 323	Continued From page 19 An observation on 7/23/14, at 7:19 a.m. of R83's room revealed no non-skid strips were at the bedside on the floor. An incident report, dated 7/15/14 indicated R83 had fallen approximately at 2:30 a.m. The incident report indicated new intervention implemented to prevent repeat incident was non-skid strips applied to floor at bedside. An individual resident care plan, dated 7/15/14 indicated non-skid strips were placed at bedside. On 7/24/14, at 8:45 a.m. an interview with registered nurse (RN)-A revealed nurses fill out a maintenance request for non-skid strips to be applied to a resident's floor, and non-skid strips should have been on the floor by R83's bedside. At 8:51 a.m. RN-A verified there were no non-skid strips on the floor by R83's bed as indicated in the documentation.	F 323	identified as not having their fall prevention interventions in place. Measures put into place included In-service training for all licensed and unlicensed nursing staff were completed by the DON and the Staff Development RN on 8/13 & 8/14/14. The in-service training included communication of the care plan interventions utilizing the RIS for the direct care staff to utilize and care plan development to address fall prevention interventions. Staff training for the computer facility dude software which staff utilize to alert maintenance staff to fall interventions that require their assistance, such as application of non-skid strips to the floor was provided 1:1 by the Environmental director on 8/14/2014. Written instructions for direct care staff accessing the facility dude program were placed at each computer and wall kiosk to assist staff. Audits will be completed by the DON and/or her designee for each resident who have had a fall beginning 8/18/2014 weekly for 4 weeks to ensure compliance is achieved as it relates to accidents and supervision. The DON and/or her designee will review the audits weekly times 4 weeks, then monthly times 2 months and at least quarterly to evaluate that the corrective action is achieved and sustained. Audit results will be reviewed with the QA Committee at their regular scheduled meetings. If negative trends are identified, the QA Committee will direct further interventions to assure that compliance is achieved and maintained.QA meeting are held at least	

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F 323	Continued From page 20	F 323	quarterly unless more frequent meetings are necessary because of audit results showing negative trends. The next QA meeting will be on August 28, 2014.	
F 411 SS=D	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to offer dental services to 1 of 1 resident (R1), reviewed for dental. Findings include: R1 was admitted to the facility on 3/3/98. R1's current diagnoses per the diagnostic record included coma-persistent vegetative state, quadriplegia and tracheostomy (a surgically created hole through the neck into the trachea). R1's quarterly Minimum Data Set (MDS)	F 411	DON spoke to the local dentist on 8/11/2014 to schedule an appointment for R1. The dentist stated he would contact DON the week beginning on 8/18/2014 to schedule a time he could come to the facility instead of making arrangements to transport R1 to his office. R1□s family member was notified on 8/11/14 of the upcoming dental visit, (date to be determined) and is in agreement to this plan. A facility wide audit performed by the social workers was started on 7/31 and	8/27/14

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 _____	07/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY CAMPUS OF CARE	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 411	Continued From page 21 completed on 6/17/14, indicated R1 was comatose and totally dependent on staff for all activities of daily life (including personal hygiene, oral care). R1's Care Area Assessments (CAAs) completed on 1/2/14, identified triggered areas of urinary incontinence, nutritional status, feeding tube, dehydration and pressure ulcer. Dental and activities of daily living (ADLs) were not triggered. The CAAs summaries did identify R1 was unable to communicate his needs and was totally dependent on staff for all ADLs. R1's plan of care dated 10/14/06, identified a problem with personal hygiene due to persistent vegetative state related to traumatic brain injury. Approaches listed included R1 needed and received total assist of one to two staff for personal hygiene. Staff were to notify a nurse with any changes or concerns. Dental services were not addressed on the care plan. During interview on 7/21/14, at 3:39 p.m. R1's family member (FM)-A reported she came to the facility on almost a daily basis and had never seen staff brush R1's teeth. FM-A reported staff occasionally wiped R1's mouth with a pink toothette, however this was not done on a daily basis. She reported R1 had two toothbrushes available to him. R1 was observed to have two toothbrushes in his medicine cabinet in a basin. The toothbrushes and basin were dry. One of the toothbrushes was battery-operated and was non-functional. A second interview was completed with FM-A on 7/23/14 at 1:30 p.m. She reported R1 had seen the consultant dentist when he (consultant	F 411	will be completed by 8/20/2014. As of 8/15/2014 eighteen residents were identified at risk related to the offering of dental services. The social worker contacted the identified residents legal representatives and twelve declined having dental services provided at this time. The remaining six residents legal representatives have not yet responded and contact will be reattempted no later than 8/27/2014. Measures put into place include having social service staff start offering/discussing dental services to each resident during their resident interviews and assessments which are completed on admission and at least quarterly. For residents who are unable to communicate related to their cognition, the residents legal representatives will be asked upon admission and at least quarterly. Audits will be completed by the DON and/or her designee for each admission beginning 8/18/2014 weekly for 4 weeks to ensure compliance is achieved as it relates to dental services. The DON and/or her designee will review the audits weekly times 4 weeks, then monthly times 2 months and at least quarterly to evaluate that the corrective action is achieved and sustained. Audit results will be reviewed with the QA Committee at their regular scheduled meetings. If negative trends are identified, the QA Committee will direct further interventions to assure that compliance is achieved and maintained.QA meeting are held at least quarterly unless more frequent meetings	

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F 411	Continued From page 22 dentist) was at the facility. She reported the dentist would come directly to R1's room and preform an exam. FM-A was unable to remember when R1 was last seen by the dentist and also did not remember any staff member asking her if she would like her son seen by the dentist. She reported she very much wanted her son seen by the consultant dentist on a regular basis. During interview with registered nurse (RN)-B on 7/23/14, at 1:52 p.m. RN-B did not remember any discussion with FM-A regarding dental services for R1. An interview with social worker (SW)-A was done on 7/23/14, at 1:44 p.m. SW-A did not remember discussing dental services with FM-A. She reported dental services are generally discussed at care conferances with the resident's family. SW-A indicated FM-A generally does not attend care conferances. The faciity policy Dental Services, dated 6/4/05, directed staff to ask if resident wish to see a dentist and provide necessary help to make a dental appointment at least on an annual basis.	F 411	are necessary because of audit results showing negative trends. The next QA meeting will be on August 28, 2014.	

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	245339	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/25/2014**

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

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K 000	INITIAL COMMENTS Fire Safety A Life Safety Code Survey was conducted by the Minnesota Department Of Public Safety, State Fire Marshal Division. At the time of this survey, Mother Of Mercy Campus Of Care was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. This facility was surveyed as two separate buildings. 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 building is fully sprinkler protected and the sprinkler system is installed in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (1999 edition) The facility has a manual fire alarm system with corridor smoke	K 000		

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

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.

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	245339	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/25/2014**

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K 000	Continued From page 1 detection and 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" (1999 edition). The facility has a licensed capacity of 76 and had a census of 75 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET:	K 000		

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	245339	A. BUILDING **02 - 3RD FLOOR ADDITION** B. WING _____	**07/25/2014**

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K 000	INITIAL COMMENTS Fire Safety A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Mother of Mercy Campus of Care 2009 addition 3rd floor was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care This facility was surveyed as two separate buildings. 2009 3rd Floor Addition Mother of Mercy Campus of Care is a 3-story building with no basement. 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 building is fully sprinkled protected throughout. The facility has a fire alarm system with smoke detection in resident rooms, corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 76 beds and had a census of 75 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET:	K 000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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