*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
May 3, 2023

Administrator
Mother Of Mercy Senior Living
230 Church Avenue, Box 676
Albany, MN  56307

RE: CCN: 245339
Cycle Start Date: January 27, 2023

Dear Administrator:

On February 9, 2023, we notified you a remedy was imposed. On April 13, 2023 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of April 6, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective March 24, 2023 be discontinued as of April 6, 2023. (42 CFR 488.417 (b))

However, as we notified you in our letter of February 9, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 24, 2023. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308  Fax: 651-215-9697
Email: sarah.lane@state.mn.us

DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered

March 9, 2023

Administrator
Mother Of Mercy Senior Living
230 Church Avenue, Box 676
Albany, MN  56307

RE: CCN: 245339
Cycle Start Date: January 27, 2023

Dear Administrator:

On February 9, 2023, we informed you that we may impose enforcement remedies.

On February 17, 2023, the Minnesota Department(s) of Health and Public Safety completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition.  The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 24, 2023.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 24, 2023.  They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 24, 2023.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated.  Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans.  It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by March 24, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Mother Of Mercy Senior Living will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 24, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Judy Loecken, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

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 - Health Regulation Division 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 Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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

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 July 27, 2023 (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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245339 | A. BUILDING **02 - 3RD FLOOR ADDITION** B. WING _____ | **02/16/2023** |

| 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<br><br>FIRE SAFETY<br><br>An annual Life Safety re-certification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Mother of Mercy Senior Living Building 02 (Welcome Center), 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) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code.<br><br>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.<br><br>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.<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:<br><br>IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. | K 000 | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 03/17/2023 |

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 **02 - 3RD FLOOR ADDITION** B. WING _____ | **02/16/2023** |

| 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<br>Healthcare Fire Inspections<br>State Fire Marshal Division<br>445 Minnesota St., Suite 145<br>St. Paul, MN 55101-5145, OR<br><br>By email to:<br>FM.HC.Inspections@state.mn.us<br><br>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:<br><br>1. A detailed description of the corrective action taken or planned to correct the deficiency.<br><br>2. Address the measures that will be put in place to ensure the deficiency does not reoccur.<br><br>3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.<br><br>4. Identify who is responsible for the corrective actions and monitoring of compliance.<br><br>5. The actual or proposed date for completion of the remedy.<br><br>Building 02 (Welcome Center):<br>Mother of Mercy Senior Living is a 3 story building with no basement. The building was constructed at 3 different times. The original building is a 2 story building without basement that was constructed in 1983 and is determined to be of Type II(222) construction. In 1999, a 1 story addition (Welcome Center) 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 | K 000 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245339 | A. BUILDING **02 - 3RD FLOOR ADDITION** B. WING _____ | **02/16/2023** |

| 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<br>(111) construction. The facility was surveyed as two facilities.<br><br>The facility has 2 hour fire separations between the 1983, 1999, and 2009 buildings and additions. The facility has been divided and inspected as 2 separate buildings. Building 02 consists of the 1999 Welcome Center addition, located on the east wall of the 2nd floor and is determined to be of type V(111).<br><br>The building is fully sprinkler protected and has a manual fire alarm system with corridor smoke detection and smoke detection in spaces open to the corridors that is monitored for automatic fire department notification.<br><br>The facility has a capacity of 65 beds and had a census of 53 at the time of the survey.<br><br>The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: | K 000 | | |
| K 211 SS=E | Means of Egress - General<br>CFR(s): NFPA 101<br><br>Means of Egress - General<br>Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11.<br>18.2.1, 19.2.1, 7.1.10.1<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to maintain a means of egress continuously maintained free of all obstructions | K 211 | Tag Number description Fire Safety K211 Means of Egress - General K211 CFR(s): NFPA 101 | 4/6/23 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245339 | A. BUILDING **02 - 3RD FLOOR ADDITION** B. WING _____ | **02/16/2023** |

| 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 211 | Continued From page 3<br>per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.1, 7.1.6.2, 7.1.6.4, and 7.1.10.1. This deficient finding could have a patterned impact on the residents within the facility.<br><br>Findings include:<br><br>On 02/16/2023 between 09:30 AM and 12:30 PM, it was revealed by observation that the sidewalk outside the North Exit door was covered with ice.<br><br>An interview with the Maintenance Director verified this deficient finding at the time of discovery. | K 211 | 1. A detailed description of the corrective action taken or planned to correct the deficiency.<br>The North Exit door was cleared of ice and snow.<br>2. Address the measures that will be put in place to ensure the deficiency does not reoccur.<br>Maintenance staff education provided to ensure that all means of egress are free of all obstructions; including ice and snow.<br>3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.<br>Maintenance director or designee will complete an audit of random means of egress every other week to assure those means of egress are free of obstruction.<br>4. Identify who is responsible for the corrective actions and monitoring of compliance.<br>The maintenance director will review and report the findings of the audits at the next quarterly quality assurance committee and review for ongoing auditing scheduling.<br>5. The actual or proposed date for completion of the remedy<br>3/6/23 | |

| 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 02/17/2023 |

| 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 |
|---|---|---|---|---|
| E 000 | Initial Comments<br><br>On 2/13/23 through 2/17/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance.<br><br>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. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>On 2/13/23 through 2/17/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.<br><br>In addition to the recertification survey, the following complaints were reviewed:<br><br>The following complaints were reviewed with no deficiency issued: H5339052C (MN81286); H53398257C (MN85499); H53398205C (MN87283 / MN87285); H53398255C (MN85032); H53398275C (MN89234); H5339051C (MN80567).<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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. | F 000 | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 03/17/2023 |

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 _____ B. WING _____ | C 02/17/2023 |

| 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 | Continued From page 1<br><br>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained. | F 000 | | |
| F 584 SS=D | Safe/Clean/Comfortable/Homelike Environment<br>CFR(s): 483.10(i)(1)-(7)<br><br>§483.10(i) Safe Environment.<br>The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>The facility must provide-<br>§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.<br>(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.<br>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.<br><br>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;<br><br>§483.10(i)(3) Clean bed and bath linens that are in good condition;<br><br>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);<br><br>§483.10(i)(5) Adequate and comfortable lighting | F 584 | | 3/22/23 |

| 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 02/17/2023 |

| 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 584 | Continued From page 2<br>levels in all areas;<br><br>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and<br><br>§483.10(i)(7) For the maintenance of comfortable sound levels.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, the facility failed to maintain wheelchairs in good repair for 2 of 2 residents (R5 and R29) reviewed for wheelchair utilization.<br><br>Findings include:<br><br>R5<br>R5's face sheet indicated diagnoses of dementia, depression, and peripheral vascular disease (causes reduced blood flow to the limbs).<br><br>R5's annual Minimum Data Set (MDS) dated 11/9/22, indicated "usually" able to make herself understood and "usually" able to understand others. R5's cognition was severely impaired. R5 was dependent on physical assistance from staff for dressing, transfers and mobility.<br><br>R5's care plan last reviewed 12/7/22, indicated R5 was independent in her wheelchair in her room.<br><br>R29<br>R29's face sheet indicated diagnoses of dementia, hypertension and muscle weakness.<br><br>R29's quarterly Minimum Data Set (MDS) dated | F 584 | Corrective action for the affected Residents<br>Wheelchair arm rests were replaced for both residents R5 and R 29<br>The facility will take the following measures to ensure the same practice will not recur<br>Upon assignment of a wheelchair and quarterly, wheelchair audits will be conducted to ensure wheelchair arm rests in need of repair are identified and repaired or replaced. Additionally, staff will be educated on the need to immediately report any wheelchairs that are not in good repair.<br>The facility will identify other residents that have the potential to be affected in the same manner by<br>All residents currently utilizing wheelchairs had their arm rests inspected for condition and repair. All wheel chair armrests needing repair were forwarded to maintenance. Maintenance is in the current process of replacing or repairing affected arm rests.<br>Facility monitoring of performance to ensure that solutions are maintained.<br>Wheelchair arm rest audits 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 02/17/2023 |

| 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 584 | Continued From page 3<br>1/19/23, indicated R29 could communicate needs and cognition was moderately impaired. R29 required physical assistance from staff for dressing and transfers.<br><br>R29's care plan last reviewed 2/8/23, indicated R29 required assistance from staff for mobility in wheelchair.<br><br>On 2/13/23, at 2:03 p.m. R5 was seated in her wheelchair. Both right and left arm rests were noted to be cracked with areas of missing vinyl. R5 rubbed her hand across the right arm rest and stated, "Oh, that's rough."<br><br>On 2/13/23, at 2:47 p.m. R29 was seated in his wheelchair. Both right and left arm rests were noted to be cracked with areas of missing vinyl. R29 stated the cracks were uncomfortable when they rub on his arms.<br><br>On 2/17/23, at 8:53 a.m. occupational therapist (OT) stated therapy and maintenance departments worked together to ensure wheelchairs were well maintained. OT was not aware of any wheelchairs that needed repair or arm rests that were cracked and peeling. OT stated it was important for the arm rests to be free from cracks for skin integrity and infection control.<br><br>On 2/17/23, at 9:04 a.m. maintenance director (MD) indicated wheelchair repair, including arm rests was done by maintenance. Repair may depend on if the wheelchair belonged to the resident or the facility. If the wheelchair belonged to the resident, the facility would contact the resident's family for direction. MD was not aware | F 584 | reviewed quarterly at QA. The results and response to the audits will be reviewed with the members of the QA committee to determine the appropriateness for on going review of the wheelchair audits by the QA committee.<br><br>Date for completion 3/22/23 | |

| 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 02/17/2023 |

| 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 584 | Continued From page 4<br>of any wheelchairs currently in need of repair. MD confirmed R5's and R29's right and left wheelchair armrests needed repair.<br><br>A facility policy on wheelchair repair was requested but was not received. | F 584 | | |
| F 604 SS=E | Right to be Free from Physical Restraints<br>CFR(s): 483.10(e)(1), 483.12(a)(2)<br><br>§483.10(e) Respect and Dignity.<br>The resident has a right to be treated with respect and dignity, including:<br><br>§483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).<br><br>§483.12<br>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for | F 604 | | 4/6/23 |

| 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 02/17/2023 |

| 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 604 | Continued From page 5<br>restraints.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review the facility failed to identify medical symptom for use of seatbelt, provide least restrictive restraint for least time possible, and provide ongoing monitoring of seatbelt use for 4 of 4 residents (R1, R47, R53, R159) reviewed for restraints.<br><br>Findings include:<br><br>R1<br>R1's face sheet indicated diagnoses included persistent vegetative state, pneumonia, and quadriplegia.<br><br>R1's quarterly Minimum Data Set (MDS) dated 1/6/23, indicated R1 was not able to communicate with staff and fully dependent for physical assistance from two staff for all activities of daily living (ADLs) including repositioning, bed mobility, transfers and wheelchair mobility. MDS lacked evidence of restraints.<br><br>R1's physician orders signed 11/8/22, included use seatbelt when in wheelchair as safety device related to positioning every shift. However, lacked evidence of medical symptoms treated.<br><br>R1's care plan last reviewed 1/26/23, failed to provide direction on use of seat belt.<br><br>Progress note dated 1/20/23, indicated R1 did not use restraints. R1 was in a persistent vegetative state with quadriplegia and contractures, totally dependent with ADLs and mobility. R1 was unable to move or reposition independently. A | F 604 | Corrective action for the affected Residents<br>A Physical device assessment policy addressing restraints was established. Physical Device assessments have been completed for R1, R47, R53 and R159. Each resident was evaluated for seat belt use, medical symptom, purpose, and other alternatives for seatbelt use. After completion of the physical device assessment, the use of a seatbelt was discontinued for R1 and R159. R47 and R53 were determined to have a medical symptom and need of the seatbelt to aide in positioning and seating for comfort and most effective use of customized seating. In collaboration with therapy for the two residents identified as having a need for the seatbelt, R47 and R53 and/or their representative were provided education on risks vs benefits of having a seatbelt. They both indicated they still want the seat belt. The doctor was notified in both situations and in agreement with use; provider order was obtained to utilize the seatbelt and the use of the seatbelt was care planned.<br>Ongoing monitoring and assessments of seatbelt use will be completed quarterly, with significant change in condition, and as needed.<br>The facility will take the following measures to ensure the same practice will not recur<br>As residents admit with an electric wheel/ obtain a new electric wheelchair or | |

| 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 02/17/2023 |

| 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 604 | Continued From page 6<br>seat belt was used while in wheelchair to ensure safety and placement. R1 was not able to make purposeful movements independently.<br><br>R1's Physical Device Evaluation dated 1/6/23, indicated the facility failed to identify the powered wheelchair (PWC) seatbelt as a restraint, alternative interventions attempted, ongoing monitoring for use, and ability to release the seatbelt independently.<br><br>On 2/16/23, at 8:52 a.m. R1 was observed seated in wheelchair, reclined back approximately forty-five degrees, with the seat belt secured across the abdomen.<br><br>On 2/16/23, at 9:37 a.m. trained medication aid (TMA)-A confirmed placement of the seat belt. TMA-A stated R1 had always used the seat belt and was not be able to remove it independently.<br><br>R47<br>R47's face sheet indicated diagnoses included stroke, quadriplegia, and epilepsy.<br><br>R47's MDS dated 2/3/23, indicated R47 had unclear speech, usually understood others, severe cognitive impairment and required extensive to total physical assistance of two staff for bed mobility, transfers, dressing, eating, toilet use, bathing, and personal hygiene. However, the MDS did not indicate the use of restraints.<br><br>R47's physician orders signed 1/26/23, included an order effective 9/17/22, to apply seatbelt when seated in PWC to provide safety, proper position, and mobility every shift. However, lacked evidence of medical symptoms treated. | F 604 | receive a customized wheelchair seating that includes a seatbelt attachment, a physical device assessment will be completed to determine if the wheelchair seat belt would be appropriate with in established policy and procedure.<br>The facility will identify other residents that have the potential to be affected in the same manner by<br>All residents with an electric wheelchair or a wheelchair that has a seat belt attached have been identified and a physical device assessment completed. No further residents currently have appropriate need of a seatbelt, or they are independent with its use.<br>Facility monitoring of performance to ensure that solutions are maintained.<br>RN Managers and therapy department have been educated to the physical device assessment policy and have been educated to alert the DON and IDT as residents admit with an electric wheel/ obtain a new electric wheelchair or receive a customized wheelchair seating that includes a seatbelt attachment. The DON and IDT will work in collaboration with the RN manager and therapy to ensure a physical device assessment will is completed to determine if the wheelchair seat belt would be appropriate with in established policy and procedure.<br>COMPLETION DATE 4/5/2023 | |

| 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 02/17/2023 |

| 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 604 | Continued From page 7<br><br>R47's care plan last revised 11/21/22, lacked evidence of seatbelt interventions or tasks.<br><br>R47's progress note dated 11/18/22, indicated R47 had no use of restraints. However, had a PWC seatbelt for safety.<br><br>R47's Restraint/Adaptive Equipment Use Assessment dated 7/7/22, indicated the facility failed to identify the use of a PWC seatbelt as a restraint, but as an adaptive device. Additionally, the assessment lacked evidence alternatives were tried, failed to identify medical symptom treated, ongoing monitoring, and ability to release the seatbelt independently.<br><br>R47's Physical Device Evaluation dated 2/3/23, failed to identify the PWC seatbelt as a restraint, alternative interventions attempted, ongoing monitoring for use, and ability to release the seatbelt independently.<br><br>On 2/14/23, at 8:32 a.m. R47 was observed in the dining room seated upright in PWC with seatbelt secured around abdomen.<br><br>On 2/14/23, at 4:24 p.m. nursing assistant (NA)-B stated R47 used a PWC with seatbelt, and all residents with PWC had seatbelts. R47 was not able to unbuckle the belt independently. NA-B was not aware why the seatbelt was needed.<br><br>On 2/15/23, at 10:24 a.m. NA-A stated R47 used a seatbelt to protect her from falling or getting hurt while seated in the PWC. R47 was not able to unbuckle it herself, and therefore, it was a restraint. Further, NA-A stated it was not safe for residents to use a PWC without a seatbelt. | F 604 | | |

| 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 02/17/2023 |

| 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 604 | Continued From page 8<br><br>On 2/15/23, at 10:36 a.m. R47 was observed alone in room, seated in PWC, reclined back approximately thirty-degrees, with the seatbelt secured around abdomen.<br><br>On 2/15/23, at 10:45 a.m. TMA-B stated R47 was not able to move her arms and did not have the ability to release the PWC seatbelt independently. All residents with a PWC used a seatbelt, and "technically" the seatbelts were restraints.<br><br>On 2/15/23, at 1:05 p.m. R47 was observed in PWC with seatbelt secured around abdomen. TMA-B confirmed placement of the seat belt. R47 shook her head from side-to-side when asked if she was able to remove the seatbelt.<br><br>R53<br>R53's face sheet indicated diagnoses included amyotrophic lateral sclerosis (a nervous system disease that weakens muscles), epileptic seizures, and Parkinson's disease.<br><br>R53's significant change MDS dated 12/9/22, indicated R53 had unclear speech, usually understood others, intact cognition and required extensive to total physical assistance of two staff for bed mobility, transfers, dressing, eating, toilet use, bathing, and personal hygiene. However, the MDS did not indicate the use of restraints.<br><br>R53's physician orders signed 1/3/23, included an order effective 9/18/22, to apply seatbelt when seated in PWC to provide safe and adequate seating and mobility every shift. However, lacked evidence of medical symptoms treated.<br><br>R53's care plan last revised 12/20/22, failed to | F 604 | | |

| 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 02/17/2023 |

| 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 604 | Continued From page 9<br>provide seatbelt interventions or tasks.<br><br>Progress note dated 12/20/22, indicated R53 had no use of restraints. However, had a seatbelt for PWC for safety.<br><br>R53's Restraint/Adaptive Equipment Use Assessment dated 7/7/22, indicated the facility did not identify the PWC seatbelt as a restraint, but as an adaptive device. Additionally, the assessment lacked evidence alternatives were tried, failed to identify medical symptom treated, ongoing monitoring, and ability to release the seatbelt independently.<br><br>R53's Physical Device Evaluation dated 12/8/22, failed to identify the PWC seatbelt as a restraint. The assessment lacked evidence alternatives were tried, failed to identify an appropriate medical symptom for use, on going monitoring, and ability to release the seatbelt independently.<br><br>On 2/14/23, at 9:31 a.m. R53 was observed in the hallway, seated in PWC with a seatbelt secured around abdomen.<br><br>On 2/14/23, at 4:24 p.m. R53 was observed in PWC with seatbelt secured around abdomen. NA-B confirmed placement of the seat belt. R53 was unable to unbuckle the seatbelt. NA-B stated R53 needed the seatbelt for safety because R53 "kind of leans in the chair".<br><br>On 2/15/23, at 10:24 a.m. NA-A stated R53 had a PWC seatbelt for safety "because she drives herself around". She had reduced hand strength and was not able to release the seatbelt independently. | F 604 | | |

| 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 02/17/2023 |

| 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 604 | Continued From page 10<br>On 2/15/23, at 10:45 a.m. TMA-B stated R53 had a PWC seatbelt because she leaned to one side and liked to "tilt back". R53 was not able to release the seatbelt independently, and the seatbelt could be a restraint.<br><br>R159<br>R159's face sheet indicated diagnoses included dementia, bilateral artificial knee replacements, and Parkinson's disease.<br><br>R159's admission MDS dated 2/9/23, indicated moderate cognitive impairment, and required extensive assistance of two staff for bed mobility, transfers, dressing, toilet use, and bathing. However, the MDS did not indicate the use of restraints.<br><br>R159's care plan last revised 2/15/23, failed to provide seatbelt interventions or tasks.<br><br>Physician Fax Order form, signed 2/10/23, indicated seatbelt while in PWC for safety, and turn off controls of power wheelchair when in room alone. However, lacked evidence of medical symptoms treated.<br><br>R159's progress note dated 2/15/23, indicated R159 had no use of restraints.<br><br>Progress note dated 2/16/23, indicated R159 was found to have unbuckled his seatbelt while in his PWC. It was reattached. R159 did not comprehend why seatbelt was needed, and education on safety was provided.<br><br>R159's Physical Device Evaluation dated 2/2/23, failed to identify the PWC seatbelt. The assessment lacked evidence alternatives were | F 604 | | |

| 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 02/17/2023 |

| 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 604 | Continued From page 11<br>tried, failed to identify an appropriate medical symptom for use, ongoing monitoring, and ability to release the seatbelt independently.<br><br>On 2/13/23, at 7:22 p.m. R159 was observed alone in room, seated in a PWC with a seatbelt secured around abdomen. Licensed practical nurse (LPN)-A entered R159's room to administer medications. After LPN-A administered eye drops, R159 asked LPN-A to remove the seatbelt. LPN-A told R159 he "needed it for safety". After LPN-A administered R159's inhaler, R159 asked LPN-A to remove his seatbelt. LPN-A told R159 he needed to keep the seatbelt on while he was in the PWC for his safety.<br><br>On 2/14/23, at 4:24 p.m. NA-B stated R159 had a PWC seatbelt as a fall prevention because he attempted to self-transfer. However, R159 had not fallen in the facility. R159 had a manual wheelchair when he was admitted to the facility, and use of the seatbelt was initiated once the PWC arrived. NA-B found R159 seated in his PWC once without the seatbelt secured, but she did not know if R159 released it himself.<br><br>On 2/15/23, at 10:45 a.m. TMA-B stated R159 had a PWC seatbelt, did not know why the seatbelt was used, and had not observed R159 attempt to self-transfer. On 2/13/23, R159 tried to release the seatbelt, was unable to, and requested a knife so he could cut the seatbelt off.<br><br>On 2/15/23, at 11:40 a.m. registered nurse (RN)-A stated seatbelts were used for residents with PWCs for safety, and that R1, R47, and R53 would not be able to unbuckle the seatbelt independently. RN-A stated R159 probably would have been able to unbuckle the seatbelt, but the | F 604 | | |

| 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 02/17/2023 |

| 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 604 | Continued From page 12<br>facility had not assessed R159's ability. RN-A stated seatbelts were not used prior to September 2022, when she was instructed by the previous DON to implement use of the seatbelts as a fall prevention, to get physician orders for use, and to note the use of a seatbelt on the quarterly Physical Devices Evaluations. RN-A stated the seatbelt was a restraint if the resident was not able to open it independently, and was not aware of seatbelt use on the residents' Plan of Care.<br><br>On 2/15/23, at 2:21 p.m. director of nursing (DON) stated use of the seatbelt as a restraint depended on the purpose and how the facility used them. She was not aware which residents used them or if the facility had a system or policy in place when residents were not able to release them independently. DON stated she became aware of the use of seatbelts with PWCs the week prior when R159 was admitted to the facility and RN-A stated R159 needed an order for the PWC seatbelt. DON stated the seatbelt was a "safety thing" and R159's responsible party requested the seatbelt. RN-A was instructed to refer to the facility policy because she was "not used to people using seatbelts", and she did not know if R159 had been assessed for a restraint. The seatbelt would be a restraint if it was used to prevent a resident from getting out of the PWC independently and if they were not able to verbalize they wanted the seatbelt released or release it on their own.<br><br>On 2/17/23, at 11:22 a.m. the DON confirmed R47's Physical Device Evaluation indicated use of a seatbelt with use of PWC per physician order, and the device was used as a therapeutic intervention for positioning and balance. DON | F 604 | | |

| 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 02/17/2023 |

| 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 604 | Continued From page 13<br>stated R47's device assessment did not contain a "good note" that explained the use or whether R47 was able to release the seatbelt. The DON confirmed R53's Physical Device Evaluation indicated a physician order for a PWC seatbelt, and did not indicate R53 had the ability to release the seatbelt. DON confirmed R159 did not have Physical Device Evaluation completed for the PWC seatbelt or documentation that indicated R159 was assessed for independent seatbelt removal.<br><br>On 2/17/23, at 11:35 a.m. DON stated at the "morning meeting" on 2/10/23, RN-A informed her an order for a PWC seatbelt for R159 was requested. She had not looked for a policy on 2/10/23, had not ensured that a process for the use of restraints had been followed, but planned to "follow-up on Monday [2/13/23]". She was not aware the facility did not have a restraint policy until 2/13/23. The DON confirmed R1, R47, R53, and R159's records lacked the documented purpose and medical symptom for use, assessment of the medical symptoms that warrant the restraint, documented alternatives attempted, documented consent with risks/benefits, and the time/frequency of use. This should have been completed prior to use of the seatbelts. Documented re-evaluation for continued restraint use and effectiveness in treating the identified medical symptoms, documented monitoring, care planned interventions to prevent risks related to use, and documented interventions for reducing the use of the seatbelts were required for use of any restraint.<br><br>The facility's Physical Device Assessment policy, effective 2/2023, defined a physical restraint as | F 604 | | |

| 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 02/17/2023 |

| 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 604 | Continued From page 14<br>any method that is attached or adjacent to the resident's body, cannot be removed easily by the resident, restricts the resident's freedom of movement or normal access to his/her body, and has the potential of many negative side effects and risks that outweigh any benefit from their use. In the rare and infrequent instances in which the medical symptoms warrant the use of a physical restraint, a physical device assessment would be completed, need/request would be reviewed with the DON, and provider orders would be obtained. Additionally, the identification, care planning and communication of the following would be completed: medical symptoms which warranted the use of the restraint; the less restrictive alternatives attempted; risks, benefits, and alternatives reviewed with resident/resident representative; identification, development and implementation of interventions to prevent/reduce the potential for risks; length of time restraint was anticipated to be used; who would apply the restraint; when and how the restraint would be used; time and frequency the restraint would be released; type of monitoring and supervision provided during use; and when on-going reassessment would be completed to determine the effectiveness and continued need. | F 604 | | |
| F 684 SS=D | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered | F 684 | | 4/6/23 |

| 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 02/17/2023 |

| 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 684 | Continued From page 15<br>care plan, and the residents' choices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure physician orders were followed for 1 of 5 residents (R43) reviewed for unnecessary medications.<br><br>Findings include:<br><br>R43's admission Minimum Data Set (MDS) dated 1/24/23, indicated R43 had moderate cognitive impairment, heart failure, and chronic kidney disease.<br><br>R43's Order Summary Report included the following orders:<br>1) Order dated 1/17/23, for daily weight in the morning for medication monitoring.<br>2) Order dated 1/18/23, for furosemide (a diuretic) oral tablet 40 mg. Give 20 mg by mouth in the afternoon related to heart failure. If weight less than 158, then take 40 mg daily. If weight 159-162 then 40 mg in AM and 20 mg in PM. If weight 163 or higher then take 40 mg twice daily.<br>3) Order dated 1/18/23, for furosemide oral tablet 40 mg. Give 40 mg by mouth in the morning related to heart failure.<br><br>R43's Weights and Vitals Summary indicated the following weights:<br>On 1/19/23, 161.2 lbs.<br>On 1/29/23, 157 lbs.<br>On 1/30/23, no weight documented<br>On 2/2/23, 160.2 lbs.<br><br>R43's Medication Administration Record (MAR) dated 1/1/23 to 1/31/23, indicated the following:<br>On 1/19/23, furosemide 40 mg was administered | F 684 | Description of how the requirement was not met.<br>The facility failed to ensure physician orders were followed for 1 of 5 residents (R43) reviewed for unnecessary medications.<br>Corrective action for the affected Residents<br>Orders for R43 weight parameters and furosemide were reviewed again with provider and the provider provided an update to the order so it reads more clearly to staff as they administer the furosemide.<br>The facility will take the following measures to ensure the same practice will not recur<br>Audits are being completed for furosemide orders that are dependent on weight parameters. To identify if medication errors are occurring and if order reads clearly for staff to follow. No order clarifications or changes have been needed.<br>Medication pass audits are being completed to determine competency of staff passing medications.<br>The facility will identify other residents that have the potential to be affected in the same manner by<br>All residents with furosemide orders dependent on weight parameters have the potential to be affected. Audits are being completed for furosemide orders that are dependent on weight parameters. To identify if medication errors are occurring | |

| 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 02/17/2023 |

| 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 684 | Continued From page 16<br>at 8:00 a.m. and furosemide 40 mg was administered at 2:00 p.m.<br>On 1/29/23, furosemide 40 mg was administered at 8:00 a.m. and furosemide 20 mg was administered at 2:00 p.m.<br>On 1/30/23, furosemide 40 mg was administered at 8:00 a.m. and furosemide was not administered at 2:00 p.m.<br><br>R43's Medication Administration Record (MAR) dated 2/1/23 to 2/28/23, indicated the following:<br>On 2/2/23, furosemide 40 mg was administered at 8:00 a.m. and furosemide 40 mg was administered at 2:00 p.m.<br><br>R43's progress note dated 1/30/23, at 3:03 p.m. indicated R43's 2:00 p.m. furosemide was not given because R43's weight was not taken that morning. Evidence the physician was notified was not found in R43's record.<br><br>On 2/17/23, at 10:20 a.m. director of nursing (DON) confirmed R43 did not receive furosemide as ordered at 2 p.m. on 1/19, 1/29, 1/30, and 2/2/23. DON confirmed furosemide was held on 1/30/23, at 2:00 p.m. because the weight was not taken that morning, and she would have expected the staff to obtain a weight at that point and update the provider for further instruction. On 1/19/23, R43's weight was between 159 and 162 lbs, 20 mg of furosemide should have been administered. On 1/29/23, R43's weight was less than 158 lbs, R43 should not have been administered furosemide at 2:00 p.m. On 2/2/23, R43's weight was 160.2 lbs, R43 should have received 20 mg of furosemide at 2:00 p.m. R43 did not receive the correct doses and the provider should have been notified. DON was aware the order was complicated and did not know what | F 684 | and if order reads clearly for staff to follow.<br>Facility monitoring of performance to ensure that solutions are maintained.<br>Monthly for the next 3 months audits will be completed for furosemide orders that are dependent on weight parameters.<br>Weekly for the next 3 months random medication pass audits will be completed.<br>Results of furosemide order audits and med pass audits will be reviewed with QA committee members to determine the appropriateness/frequency of ongoing audits.<br>COMPLETION DATE 4/5/2023 | |

| 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 02/17/2023 |

| 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 684 | Continued From page 17<br>errors had been made. DON had instructed RN-A to "address the order" with the provider, and the provider wanted to keep the parameters as written. A second request for clarification was sent via fax to the provider on 1/30/23, and the provider wanted to keep the order as written. DON stated after the second request for clarification was unsuccessful, she "probably should have called him myself". Because the order was confusing, she would have expected the nurse manager to monitor to ensure the medication was administered appropriately, but she had not instructed the nurse manager to monitor the administration. DON stated receipt of the correct dosage of furosemide was important for cardiac and kidney function, and R43 could have adverse effects if he did not receive the correct dose of furosemide.<br><br>On 2/17/23, at 11:56 a.m. registered nurse (RN)-A stated she was instructed by the DON to get the order clarified, and the previous primary provider sent back the same order. RN-A planned to notify the provider that staff did not know what to do when R43's weight fell between the ordered parameters. RN-A stated she was not supposed to enter the parameters into the system so they were clearer and had to input parameters exactly as written by the provider.<br><br>The facility's Medication Guidelines policy, last approved 11/2021, indicated the provider would be contacted for any necessary order clarifications, and clarifications would be documented in the medical record. | F 684 | | |
| F 745 SS=G | Provision of Medically Related Social Service CFR(s): 483.40(d) | F 745 | | 4/6/23 |

| 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 02/17/2023 |

| 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 745 | Continued From page 18<br>§483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to provide medically related social services for 1 of 1 residents (R23) who expressed desire to be moved to another facility. The failed practice resulted in psychosocial harm when the facility failed to follow up on recommendations R23 be assisted in finding alternate placement at a lower level of care (LOC).<br><br>Findings include:<br><br>R23's face sheet printed 2/17/23, indicated R23's diagnoses included Friedrich's ataxia (causes difficulty walking, loss of sensation in arms and legs and impaired speech).<br><br>R23's quarterly Minimum Data Set dated 12/14/22, indicated R23 was able to communicate needs and cognition was intact. R23 required physical assistance from staff with transfers, grooming, bathing, repositioning, and toileting.<br><br>R23's care plan, revision date 11/8/22, indicate R23 wished to remain in the facility for long term care (LTC). R23 requested to be asked about returning to the community only with comprehensive assessments. No active discharge planning was in place at time of revision.<br><br>Associated Clinic of Psychology (ACP) note dated | F 745 | Corrective action for the affected Residents<br>Contacts have been made to Senior Linkage Line, Disability Hub, Stearns and Morrison County. R23 identified wishes to discharge to a group home setting., however no particular site was identified. Referrals have been made however at this time no accepting facility has been identified that can meet the resident□s physical needs.<br>The facility will take the following to ensure the same practice will not recur<br>The facility will review resident and/or resident representative wishes for continued stay versus discharge wishes upon admission, quarterly and as needed to assure residents social service needs are met.<br>The facility will identify other residents that have the potential to be affected in the same manner by<br>DON or designee will audit care conference notes monthly to ensure residents and/or resident representatives continued stay wishes are reviewed.<br>Facility monitoring of performance to ensure that solutions are maintained.<br>Results of audits will be reviewed with QA committee members to determine the appropriateness/frequency of ongoing audits.<br>COMPLETION DATE 4/5/2023 | |

| 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 02/17/2023 |

| 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 745 | Continued From page 19<br>7/27/22, recommended R23 would benefit from a level of care (LOC) to enable him to thrive and not just survive.<br><br>ACP note dated 10/5/22, directed again consider a different level of care due to [23's] age and socialization needs.<br><br>ACP note dated 12/6/22, directed please consider a group home or other living environment as this is too restrictive LOC for this client [R23].<br><br>Progress note dated 12/9/22, noted ACP visit: plan/recommendations: please consider a group home or other living environment as this is too restrictive a LOC for this client. Additional progress notes reviewed 10/1/22-2/14/23, no other notes found to indicate attempts were made to find alternate placement for R23.<br><br>On 2/13/23, at 1:08 p.m. R23 was crying and voiced his desire to live in an environment with people closer to his age and cognitive level. R23 reported no facility staff have talked with him about other living options or discharge.<br><br>On 2/16/23, at 1:55 p.m. R23 was observed crying as he stated no other residents in the facility were on the same cognitive level as he was, "its like being with a bunch of three-year-olds." R23 voiced concern he would be treated as a three-year-old as his condition continued to decline. Further, facility staff had not asked R23 how he felt about living at the facility, "its not that good."<br><br>On 2/16/23, at 2:13 p.m. nurse manager (NM)-C indicated she knew she needed to read provider notes, including ACP notes and document the | F 745 | | |

| 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 02/17/2023 |

| 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 745 | Continued From page 20<br>visit in R23's progress notes, but was not aware she needed to follow up on recommendations. She was not aware R23 desired to live in a less restrictive environment and had not talked with R23 about how living in the facility made him feel.<br><br>On 2/17/23, at 9:17 a.m. director of nursing (DON) stated she had not asked R23 how he felt about living in the facility with others who were much older. R23's physical needs required the level of care provided by the facility. DON agreed there was potential to help R23 find a facility to meet his physical needs and also able to meet his socialization needs. DON expected the nurse manager to review ACP progress notes and follow up on recommendations that were made. DON confirmed, discharge planning was not started for R23.<br><br>Facility policy, Discharge Planning dated 12/2021 indicated all residents will have assistance with discharge planning. | F 745 | | |
| F 867 SS=F | QAPI/QAA Improvement Activities<br>CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii)<br><br>§483.75(c) Program feedback, data systems and monitoring.<br>A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:<br><br>§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such | F 867 | | 4/6/23 |

| 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 02/17/2023 |

| 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 867 | Continued From page 21<br>information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.<br><br>§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.<br><br>§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.<br><br>§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.<br><br>§483.75(d) Program systematic analysis and systemic action.<br><br>§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.<br><br>§483.75(d)(2) The facility will develop and implement policies addressing:<br>(i) How they will use a systematic approach to determine underlying causes of problems | F 867 | | |

| 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 02/17/2023 |

| 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 867 | Continued From page 22<br>impacting larger systems;<br>(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and<br>(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.<br><br>§483.75(e) Program activities.<br><br>§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.<br><br>§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.<br><br>§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs | F 867 | | |

| 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 02/17/2023 |

| 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 867 | Continued From page 23<br>(c) and (d) of this section.<br><br>§483.75(g) Quality assessment and assurance.<br><br>§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:<br><br>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;<br>(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure the quality assessment and assurance committee (QAA) developed and/or maintained an appropriate systemic action plan for provider recommendations, as previously cited in survey exited 11/18/21. Additionally, the facility failed to develop and implement appropriate action plans to correct quality deficiencies identified during the survey related to restraints. This deficient practice had the potential to affect all 53 residents currently residing in the facility.<br><br>Findings include:<br><br>On 2/16/23, at 2:13 p.m. nurse manager (NM)-C stated she knew she needed to read provider notes, including Associated Clinic of Psychology (ACP) notes and document the visit in a progress | F 867 | The facility will take the following measures to ensure the same practice will not recur<br>The facility will revise the standing agenda for the quarterly quality assurance committee to include a review of recent survey activity and review for ongoing compliance.<br><br>The facility will identify other residents that have the potential to be affected in the same manner by<br>The facility administrator will review the quality assurance notes to assure recent survey activity and ongoing compliance is addressed in the quarterly committee meeting.<br>Facility monitoring of performance to ensure that solutions are maintained. | |

| 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 02/17/2023 |

| 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 867 | Continued From page 24<br>note. However, NM-C was not aware she needed to follow up on provider recommendations indicated in the provider notes.<br><br>On 2/17/23, at 9:17 a.m. director of nursing (DON) stated she expected the nurse manager to review ACP progress notes and follow up on provider recommendations.<br><br>AND<br><br>On 2/15/23, at 2:21 p.m. director of nursing (DON) stated use of a power wheelchair (PWC) seatbelt as a restraint depended on the purpose and how the facility used them. She was not aware which residents used seatbelts, and if the facility had a system or policy in place to release the seatbelts if residents were not able to release them independently. DON stated the week prior, she became aware of the use of seatbelts with PWCs. She instructed staff to refer to the facility policy because she was "not used to people using seatbelts", and she did not know if residents had been assessed for a restraint. The seatbelt was a restraint if it was used to prevent a resident from getting out of the PWC independently and if they were not able to verbalize they wanted the seatbelt released or release it on their own.<br><br>On 2/17/23, at 11:22 a.m. the DON stated four residents (R1, R47, R53, R159) had physician orders for use of a seatbelt with PWC. DON confirmed physical device assessments did not contain the needed information to warrant use, nor if residents were able to release the seatbelt on their own. She became aware the facility did not have a policy for restraints on 2/13/23.<br><br>On 2/17/23, at 1:55 p.m. administrator stated | F 867 | The facility administrator will review with the QAA on the facility□s compliance with maintaining a QAA action plan for recent survey activity.<br>COMPLETION DATE 4/5/2023 | |

| 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 02/17/2023 |

| 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 867 | Continued From page 25<br>facility staff were not familiar with the purpose and processes of Quality Assurance and Performance Improvement Plan (QAPI) and QAA prior to him assuming his position as administrator. The QAA committee started putting Performance Improvement Projects (PIPS) in place, and started with some of the "easy things" so the committee representatives saw how the process worked. Committee members were instructed to propose PIP recommendations this week. QAA committee representatives will learn to develop, implement and maintain systems to address quality deficiencies.<br><br>The facility's Quality Assurance Performance Improvement policy, last approved 8/2022, indicated QAA focus areas included all systems that affected resident and family satisfaction, quality of care and services provided, and all areas that affected quality of life. | F 867 | | |
| F 881 SS=F | Antibiotic Stewardship Program<br>CFR(s): 483.80(a)(3)<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to develop antibiotic stewardship program which included implementation of protocols and a system to monitor antibiotic use | F 881 | Corrective action for the affected Residents<br>No specific residents identified. This deficient Practice had the potential to | 4/6/23 |

| 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 02/17/2023 |

| 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 881 | Continued From page 26<br>to ensure appropriate antibiotics were utilized. In addition, the facility failed to ensure prescribed antibiotics met criteria for antibiotic use and that the reassessment for continued need of the antibiotics was completed. This deficient practice had the potential to affect all 53 residents who resided in the facility.<br><br>Findings include:<br><br>A facility form, untitled, from November 2022 through February 2023, tracked actual infections and antibiotic us. The form was organized with 35 columns which included the following data: resident name, room number, infection type, symptoms, onset date, use of a device, if diagnostic testing was performed, test date, identified pathogen, date/type/duration of antibiotic treatment, provider, if the infection met criteria and if reassessment of the antibiotic was performed.<br><br>The December 2022 log identified 12 antibiotics were prescribed. Seven infections were identified as an UTI, two infections were identified as pneumonia, one was identified as an URI and one was identified as paranychia (infection in the skin surrounding the nail). One sinus infection, one pneumonia and the paranychia infection failed to include diagnostic testing. All 12 infections lacked evidence of meeting criteria. The antibiotics for each of the infections was not reassessed for appropriate use or continued need.<br><br>The December 2022 log identified eight antibiotics were prescribed. Seven infections were identified as an UTI and one infection was identified as a sinus infection. All seven infections | F 881 | affect all 53 residents who resided in the facility.<br>The facility will take the following measures to ensure the same practice will not recur<br>DON and facility infection preventionist reviewed the facility Antibiotic Stewardship Program. Additionally, the facility has added and implemented an infection control and tracking module to its electronic medical record system that will aide in the process for monitoring and reporting on the antibiotic stewardship compliance.<br>The facility will identify other residents that have the potential to be affected in the same manner by<br><br>Facility monitoring of performance to ensure that solutions are maintained.<br>The DON will complete monthly audits of prescribed antibiotics to assure the facility□s Antibiotic Stewardship program is being followed. Results of audits will be reviewed with QA committee members to determine the appropriateness/frequency of ongoing audits.<br>COMPLETION DATE 4/5/2023 | |

| 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 02/17/2023 |

| 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 881 | Continued From page 27<br>lacked evidence of meeting criteria. The antibiotics for each of the infections was not reassessed for appropriate use or continued need.<br><br>The January 2023 log identified three antibiotics were prescribed. Two infections were identified as an UTI and one was identified as an URI. All three infections lacked evidence of meeting criteria. The antibiotics for each of the infections were not reassessed for appropriate use or continued need.<br><br>The February 2023 log identified five antibiotics were prescribed. Four infections were identified as a UTI, one of the UTI's did not include diagnostic testing. One infection identified was a sinus infection. All four infections lacked evidence of meeting criteria. The antibiotics for each of the four infections were not reassessed for appropriate use or continued need.<br><br>Facility documents: Minimum Criteria for Initiation of Antibiotics in LTC (long term care) Residents with Suspected Lower Respiratory Tract Infection, Minimum Criteria for Initiation of Antibiotics in LTC Residents with Suspected Skin and Soft-Tissue Infection, Minimum Criteria for Initiation of Antibiotics in LOTC Residents with Fever or Unknown Focus of Infection and Minimum Criteria for Initiation of Antibiotics in LTC Residents with Suspected UTI each included spaces to include resident name, physician and concern. Instructions on the forms guided staff to indicate what symptoms the resident was experiencing. Space was provided on each form for the doctor to respond and provide further direction. | F 881 | | |

| 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 02/17/2023 |

| 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 881 | Continued From page 28<br>On 2/16/23, at 12:54 p.m. infection preventionist (RN-A) stated there were forms on each unit for the nurses to complete when they had a concern about a resident having a possible infection. The form guided the nurse for next steps which included indicating signs and symptoms the resident was experiencing and updating the provider. RN-A expected these forms were completed, then faxed to the doctor to update. RN-A expected a copy of the form was also given to her for tracking and surveillance. RN-A stated the forms were not completed consistently resulting in antibiotics being prescribed without meeting criteria. RN-A reviewed logs dated November 2022-February 2023 and confirmed the logs failed to indicate in the antibiotics prescribed during that time met criteria and the logs indicated reassessment of prescribed antibiotics were not completed. RN-A stated it was important to ensure criteria was met and to reassess prescribed antibiotics to ensure antibiotics were not overly used and to prevent resistance. RN-A stated she did not have sufficient time to follow up on antibiotics prescribed to ensure they met criteria and reassessed for continued use and need.<br><br>On 2/16/23, at 1:24 p.m. RN-B confirmed she was aware of the forms to complete when a resident was showing signs of a possible infection but stated she did not always use the form.<br><br>On 2/17/23, at 9:09 a.m. director of nursing (DON) stated she expected nurses to complete the minimum criteria forms when there were concerns about possible infection. DON expected the forms were used to update the providers and to give the provider all possible information before antibiotics were prescribed. DON expected RN-A | F 881 | | |

| 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 02/17/2023 |

| 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 881 | Continued From page 29<br>to review prescribed antibiotics and report concerns to the unit managers if the forms were not being completed or criteria was not being met. DON expected reassessment of prescribed antibiotics happened 72 hours after they were started. Appropriate use of antibiotics was important to prevent future resistance to antibiotics.<br><br>Facility policy, Antibiotic Stewardship Program, reviewed 11/2021, instructed the program would review new antibiotic starts to determine whether the clinical assessment and prescription documentation is in accordance with the facility policy and antibiotic use protocol. Also, to perform a review 48-72 hours after initiation of antibiotics to determine the resident's clinical response to treatment and the antibiotic choice based on test/culture results when available. | F 881 | | |
| F 883 SS=D | Influenza and Pneumococcal Immunizations<br>CFR(s): 483.80(d)(1)(2)<br><br>§483.80(d) Influenza and pneumococcal immunizations<br>§483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that-<br>(i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;<br>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;<br>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and<br>(iv)The resident's medical record includes | F 883 | | 4/6/23 |

| 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 02/17/2023 |

| 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 883 | Continued From page 30<br>documentation that indicates, at a minimum, the following:<br>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and<br>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.<br><br>§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-<br>(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;<br>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;<br>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and<br>(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:<br>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and<br>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the | F 883 | Description of how the requirement was | |

| 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 02/17/2023 |

| 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 883 | Continued From page 31<br>facility failed to ensure 1 or 4 residents (R30) admitted during the 2022/2023 influenza season (October 1 through March 31) received the influenza vaccination in accordance with the Center for Disease Control (CDC) recommendations.<br><br>Findings include:<br><br>R30's face sheet indicated diagnoses included diabetes mellitus, anemia, and heart failure.<br><br>R30's admission Minimum Data Set (MDS) dated 1/30/23, indicated cognitively intact. Additionally, the MDS indicated R30 did not receive the influenza vaccine while at the facility because she was not in the facility during the influenza vaccination season.<br><br>R30's Influenza Vaccination Consent/Declination form, signed by R30 on 1/23/23, indicated R30 had consented to receive the influenza vaccine for the 2022/2023 influenza season.<br><br>R30's admission summary progress note dated 1/23/23, at 3:30 p.m. indicated resident "declined COVID and Flu vaccines".<br><br>R30's Immunization Report printed 2/17/23, indicated R30 did not receive the influenza vaccine while at the facility.<br><br>On 2/17/23, at 10:48 a.m. director of nursing (DON) confirmed an influenza vaccination consent was signed by R30 on 1/23/23. Additionally, DON confirmed R30's medical records lacked evidence of the influenza vaccine being administered. The DON stated she considered this to be a failure in following facility | F 883 | not met.<br>The facility failed to ensure that 1 of 4 residents (R30) admitted during the 2022-2023 influenza season received the influenza vaccination in accordance with the CDC recommendations.<br>Corrective action for the affected Residents<br>R30 had already discharged from the facility, therefore was unable to receive the immunization at the facility after survey had brought it to our attention.<br>The facility will take the following measures to ensure the same practice will not recur<br>Upon admission, residents will be offered the influenza vaccine during the influenza season. Each week during the influenza season, the Infection Preventionist will review resident admission consent/declination wishes and assure that the vaccine is administered as indicated per resident and/or resident representative wishes<br>The facility will identify other residents that have the potential to be affected in the same manner by<br>Audits for all current residents have been completed to ensure that residents that have consented to the influenza immunization have received the education and the immunization unless medically contraindicated. Audits also completed to ensure that any residents that have not received an influenza immunization has proof of education and a declination on file.<br>Facility monitoring of performance to ensure that solutions are maintained. | |

| 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 02/17/2023 |

| 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 883 | Continued From page 32<br>process, and she expected residents who consented to the influenza vaccine received it within 7 days of admission.<br><br>The facility's Influenza Vaccination Policy last revised 11/2021, indicated between October 1 through March 31, all residents would be offered, and when indicated, provided the influenza vaccination according to CDC recommendation, unless medically contraindicated, already immunized, or the resident and/or the resident representative declined the vaccine. | F 883 | During the influenza season, the DON or designee will complete a monthly audit to ensure residents who consent to the influenza vaccine receive the vaccine. The results and response to the audits will be reviewed with the members of the QA committee to determine the appropriateness for ongoing review of the audits by the QA committee.<br>COMPLETION DATE 4/5/2023 | |